



Voices of Medicine



By Del Meyer, MD

A "medical" marijuana problem, ER's growing caseload, on the sidelines of a Great Game

My Neighbors the Potheads

Emily Dalton, MD, writes on "Medical Marijuana" in *The Bulletin* of the Humboldt-Del Norte Country Medical Society, July 2007.

"My neighborhood is going to pot. Literally. There is a house on our block that has little or no traffic. The window shades remain down all the time. No one comes, no one goes, nor is anyone ever seen tending to the yard. Music never emanates from the home, but a funny aroma does - fragrant, aromatic and pungent. Back when the home went up for sale I hoped a young family would move in. The neighborhood is perfect for children: a dead end cul-de-sac with scattered basketball hoops and nice lawns. Unfortunately, young families can no longer afford the nicer homes. Some-one bought it and decided to make it a rental. Renting to a grower generally allows the owner to charge double or even triple the usual amount.

"According to an officer in the Sheriff's department, an indoor grower can produce tremendous amounts of mari-juana in the space of an average living room. These indoor marijuana outfits are quite common in Humboldt County. If a complaint is received, the approach taken by the drug enforcement unit is to pay a visit and ask what is going on and why the place smells like pot. If the grower has a 215 card, things stop there. If the grower cannot produce the card, then a search warrant can be issued and arrests made.

"Think about it - the fate of these dope growers depends on a physician's authorization. How did this problem ever get thrown in our laps? Unfortunately, there is no shortage of unscrupulous doctors to dole out the 215 cards, and they undoubtedly earn more than most of the rest of us who work legitimately..."

The entire article, including references, is at www.humboldt1.com/~medsoc/images/bulletins/JULY%202007%20BULLETIN_for%20web.pdf

Non-Emergency Emergencies

Dr. Joshua Weil, chief of Emergency Medicine at Kaiser Santa Rosa, writes on "Another Straw on the Camel's Back" in *Sonoma Medicine*, the magazine of the Sonoma County Medical Association.

"It's a typical Saturday night in the Kaiser Santa Rosa emergency department. More than 30 patients crowd our 17-bed ED. Every bed is full, including the six hallway beds, and about a dozen patients are still waiting to be roomed. I pick the 'next to be seen' chart out of the rack and scan over the triage paperwork: 26-year-old female with pelvic pain and

normal vital signs. I look more closely for better detail: 'Pain for six months.' I do a double take. 'Pain for six months?' I ask myself. 'When did this become an "emergency"?"

"It's a rhetorical question in a frustrated moment. But it's one I also ask of our patients (in a less frustrated tone), to try to get a feel for what has changed when they present to the ED with chronic problems. In this case, nothing much has changed; but the patient's mother has grown tired of listening to her complain of the pain, and tonight seemed like a good time to see a doctor. With no insurance and no doctor, they headed to our ED for answers...

"Over the past few years, we have experienced a steady climb of non-Kaiser members presenting to our ED, most of them uninsured or underinsured. From the 7-8% of four or five years ago, the number of nonmembers has grown to 12-13% of the 30,000+ patients that we see each year...

"The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that any person presenting to an ED receive a medical screening exam to ensure that no life- or limb-threatening emergency exists. What constitutes a medical screening exam is open to some interpretation; but as the Department of Health Services has both the final say and the ability to levy large fines, the vast majority of patients will be seen and evaluated in the ED...

"What is clear is that the standard of care in the ED is different than in the office. While the office-based physician focuses on what is most likely to be the problem, my job is to exclude what is most likely to be the lethal diagnosis. 'Heart-burn' can be readily addressed as GERD in the clinic, whereas I am obliged to perform more rigorous evaluations to exclude coronary ischemia in that same patient. These procedural differences are even more pronounced for patients with little or no history in our system and with whom we are not familiar - especially if timely follow-up cannot be assured. In some cases, this lack of knowledge may even necessitate hospital admission, which is surely more costly...

"What may be less obvious are the hidden costs of meeting regulatory and compliance requirements, such as nurse staffing ratios and timelines for cardiac, stroke, and pneumonia patients. EDs must staff to meet these demands - and staff isn't free. Meanwhile, hospitals and EDs across California are closing even as populations are growing ..."

To read the entire article, go to www.scma.org/magazine/scp/sm07/weil.html.

Capturing the Medical Superstructure

"The Great Game" is the topic of Dr. Jason Campagna in the *Bulletin* of the California Society of Anesthesiologists, Summer, 2007.

"It was called 'The Great Game,' and it referred to the epic imperial struggle for supremacy in 19th century central Asia. For well over 100 years, The Great Game occupied the minds of the best men in the most powerful governments on the planet. Today, another Great Game is afoot - and it refers to who will control the vast resources and wealth associated with the entire medical superstructure.

"Like the Great Game of the 19th Century, there are concrete and tangible rewards to be had by playing - and winning - today's version of The Game. Then, the rewards were oil, natural gas, and other precious resources, along with the money that derived from their control. Today, the prize is the medical superstructure in its entirety. Such control allows one to lay claim to one of the most benevolent offerings one human can provide another - medical care. With this claim comes great power: power over people, and, more important, power over vast sums of money.... Like any game, some potential players remain on the sideline. Some do so for strategic reasons, while others do so out of fear. During this time, the active players make mistakes, joust with one another and withdraw. Most important, however, they learn - learn better how to play the game, how to attack

their opponents with force and brutal efficiency, and how to lie low and wait when in danger. In short, these players are getting quite good at the game, while those on the sidelines are not. This does not bode well for those observers.

"For physicians, these details of the Great Game, and understanding the players and the observers, are vitally im-portant. The key issues, unfortunately, are that physicians do not like this game, they are not very good at playing it, and, sadly, they are one of the most conspicuous of those groups now on the sidelines.... If indeed we would like to be-come players in this game, there are some things we must just simply acknowledge and then move on. Chief among these is that there is nothing inherent in the concept or title of 'physician' that grants us any cultural authority, economic power, or political influence..."

To read about those factors, go to
www.csahq.org/pdf/bulletin/issue_17/campagna072.pdf.

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