



Voices of Medicine



By Del Meyer, MD

Shutting down: instructions at the last stage of life, and reflections after closing a practice.

A "Good" Ending

Drs. Wendi Joiner and Tim Nicely discuss "The Last Stage of Life Project in Humboldt County," in the *The Bulletin* of the Humboldt-Del Norte Country Medical Society, April 2008.

What is a "good" death? This is only identifiable in the perspective of the patient and the patient's loved ones. How can we consistently provide this last service to our patients, our neighbors? Communication and coordination in the last stage of life - whether this is a few weeks or many years - are the key. Communication is a personal skill set and coordination means a system including the wide variety of persons and facilities providing services.

A diverse group sponsored by the IPA has been meeting to discuss issues related to last stage of life (LSL) care in our community since October 2006. The IPA LSL Project Committee includes clinicians, representatives of all levels of local health care facilities and emergency medical responders. A common concern is that systems are not in place to ensure that patients' wishes are consistently carried out due a lack of coordination and communication, especially between levels of care.

According to a recent survey, eight out of ten people say it is "very" or "somewhat" important to write down LSL wishes, but only 36% actually have written instructions. As a result, needless and unwanted interventions happen during the last six months of life, causing unnecessary stress and expense for patients and their families alike.

The Mission of the Last Stage of Life (LSL) Project is *to ensure that all residents of Humboldt County have their choices known and preferences honored regarding the nature and intensity of last stage of life care, support and services.*

The vision of the LSL Committee is to help the members of our community have a good death according to their own values and preferences by creating a collaborative system within and between all levels of care - home, RCF, SNF, acute hospital, emergency transport - to honor and implement documented patient preferences. The choice of a common documentation for clinician orders regarding CPR, antibiotics, artificial nutrition/hydration and hospitalization has been a key focus of work.

The Physicians' Order for Life Sustaining Treatment (POLST) form has been selected as the tool by which patient's LSL care preferences will be communicated within and between facilities. In November 2007, the Humboldt IPA received a grant from the California HealthCare Foundation to assist with implementation of the POLST. We became part of a statewide Coalition working with the California Coalition for

Compassionate Care to implement the POLST in California, based on a model in use in five other states. This group gives us a forum by which we can share ideas, materials, and experience with others across California...

To read more about the coalitions, plans, and the POLST forms, go to www.humboldt1.com/~medsoc/images/bulletins/APRIL%202008%20BULLETIN_for%20web.pdf

Thoughts After the Unthinkable

Anne French, MD, writes about "Collective Health" in the summer 2008 *Sonoma Medicine*, of the Sonoma County Medical Association.

I've done what was once unthinkable - I closed down a 45 year-old solo family practice in the fall of 2006. My father ran the ship for 42 years. I came along to experience this rare dying breed for a mere three years, and then decided it was time for hospice.

Ever since residency, I've had the sense of holding my breath, waiting for the medical system to collapse entirely, so that it can rise anew and become a viable system that truly cares for the health of our nation. When I was mired in the muck of a frantic 16-hour day filled with hundreds of detailed tasks, often involving significant liability for people's health and lives, it felt impossible to be part of the solution.

My original decision to take over my father's practice took me by surprise. I left my salaried position at the Sonoma County Indian Health Project and was propelled headlong through a crash course in small-business ownership, practice management, and being the sole provider for not only 3,000 patients, but also five employees. I learned the reality of partial and delayed reimbursements from the insurance industry, and of productivity-based income. To avoid compromising my ideal of quality, I limited the number of patients to 18-20 per day. This limit allowed me to break even, but I was still working 80 hours a week.

It's taken some retrospection to realize that I was running a private nonprofit. I loved the autonomy of solo private practice, I loved practicing my own blend of allopathic and integrative medicine, and I loved my patients. But I knew the pace was not viable, and that I was at high risk for burnout. I also could not tolerate any more incursions on my time or my income. I was getting paid for only 50% of my time and effort. Sure, my patients were happy, but the workload and the financial equation were not sustainable.

I currently work for the State of California, at the Sonoma Developmental Center. I'm on hiatus from private practice, with a strong desire to protest our current system. As long as I continued to contract with insurance companies, I was part of the problem, not the solution. I was allowing these companies to further exploit the medical system, by accepting their corrupt contracts and their delayed payments. Needless to say, a year and a half after closing my practice, I am still owed tens of thousands of dollars by the insurance companies, which still require labor-intensive redundant paperwork to refile and contest my unpaid claims...

The total amount of money going into our health care system is phenomenal, more than any other country in the world. In a typical insurance company, administrative costs range from 20% to 30%. These rates compare unfavorably with Medicare and Kaiser, whose administrative costs are less than 10%. The multiple layers of separation between patient and physician are not benefiting anyone except the insurance industry, which continues to rake in huge profits. Meanwhile, physicians and hospitals struggle to survive, and patients receive mediocre and substandard care for an ever-increasing price tag...

Many of the common arguments against universal health care continue to be recycled in repetitive campaigns to play on our fears of long lines, less choice and substandard care. Isn't that what we already have? We can create a viable, competitive new system that we actually want to use. We're a creative country (although a bit constipated at the moment), and we could use some of the benefits of our capitalist society (such as competition) to

create a universal health care system that fills us with pride, not fear.

The power and strength of the pharmaceutical and insurance lobbies is clearly stamped on our current medical model. The only way to revamp medicine is to have physicians and patients take back ownership of the system. In fact, if we don't find our voices, the "solutions" will continue to be dictated by industry lobbyists and politicians. The balance of power must be restored, and a set of checks and balances needs to be applied to the drug and insurance companies, just as they are currently applied to individual physicians. *The entire article can be read at <http://www.scma.org/magazine/scp/sm08/french.html>*

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