



Sierra Sacramento Valley Medicine
Vol. 60 / No. 6 - Nov / Dec 2009

Voices of Medicine



By Del Meyer, MD

The importance of words, two sides of dual practice, baby boomers' role in health care, and questions about Congress and health care.

Words Make a Difference

Sonoma Medicine devotes the summer issue to Cross Cultural Medicine. This article, "Care in Translation," is by Rick Flinders, MD.

Don Felipe was one of the *campesinos* I got to know best during the two years I lived in South America. He was short and dark-eyed and was one of the wisest farmers among the new homesteaders on the Paraguayan subtropical frontier.

One day as we were riding horseback to visit his parents in his native village, I made the mistake of saying I was hungry. He corrected me, saying that what I had was *appetite*, and that *hunger* was a term reserved only for those occasions when one had gone for two or three days without food. He said I had never been hungry.

When we arrived in his parents' village, we learned that little rain had fallen that spring and that the mandioca crop, his people's staple food, had failed. His parents hadn't eaten in six days. That, Felipe reminded me, was hunger. He made me promise that I wouldn't forget the meaning of *hunger* when I returned to my own country.

If so much can ride on the meaning of a single word, what are we missing in the daily exchange of language with our patients from Asia, Africa, Europe, Central America and South America? And even if we understand the language, what meaning do those words convey in the context of cultural differences that can splinter the meaning of such basic concepts as *illness, health, life and death*? We can barely agree on these terms inside our own medical and cultural paradigms.

In this issue of *Sonoma Medicine*, we explore the reality and needs of cross-cultural medicine from a variety of experiences and perspectives...

To review Dr. Flinders' synopsis go to www.scma.org/magazine/articles/?articleid=407. The Table of Contents for the summer issue is at www.scma.org/magazine/?vol=60&num=3

Dr. Flinders, a clinical professor of family and community medicine at UCSF, chairs the SCMA Editorial Board.

Why a Dual Practice?

Philip R. Alper, MD, discusses “Should the Subspecialist be a Primary Physician?” in the San Mateo County Medical Association July-August 2009 *Bulletin*.

The provision of substantial primary care by specialist physicians is a uniquely American custom. Arguably, it has upgraded primary care and narrowed the often substantial quality gap between hospital-based specialty practice and office-based general practice that is common in other countries. However, any mention of the benefits of dual practice has been drowned out by allegations that, in the United States, we have too many specialists and not enough generalists — and the result is excessive costs. Internal medicine is the best example of a specialty that has blended a commitment to primary care with concomitant subspecialty practice.

I comment on this situation having spent 30 years in the practice of general internal medicine with a subspecialty in endocrinology — principally thyroid disorders and diabetes. I value the subspecialty portion of my practice because it offers me intellectual stimulation, contact with colleagues, and the opportunity to do something “special” for patients.

There are trade-offs. For example, although endocrinology appeals to me greatly, I would hate to practice only endocrinology because I find the rest of medicine so fascinating. And whereas treating a wide range of patients enhances overall clinical acumen, it does narrow the scope of the specialty conditions that I feel qualified to treat. There are also compensations: By offering primary care to those endocrine patients whom I do follow, I see more of them and put their specialty problems in better perspective. How does my interest in a subspecialty disqualify me from effectively taking responsibility for their overall health?...

To read the entire article by Dr. Alper, go to www.smcma.org/bulletin/issues/BULLETIN-09JulyAug.pdf

Health Care and the Baby Boomers

John Kitzhaber, MD, Director of the Center for Evidence-Based Policy at Oregon Health and Science University, writes about “Health Care to Health: The Unfinished Business of the Baby Boom Generation—Part I,” in the *Bulletin of the California Society of Anesthesiologists*. His article is based on an earlier address, the full text of which is available at www.ohsu.edu/som/alumni.

In this article, I would like to accomplish four things: impress on you the urgency of the growing crisis in our health care system, provide a context for why our current system is so dysfunctional, suggest what we need to do to fix it and discuss how you might assume a leadership role in meeting this challenge.

Are you between 43 and 61 years old? We are the Baby Boom generation, the 30 percent of the U.S. population born between 1946 and 1964. Most of us are the children of those who weathered the Great Depression, served in the Second World War or who helped rebuild the world in its aftermath. They built our system of higher education, created the interstate highway system and the transmission grid, went to the moon, cured polio, eradicated smallpox and put in place the great social programs of the 20th century: Social Security, the GI Bill, Medicare and Medicaid. As a result, our generation has enjoyed more promise and more opportunity than any other generation in the history of our nation. I want you to think about what our legacy is going to be — about the kind of world we are leaving to our children and grandchildren. And on our current trajectory it is not a

pretty picture.

Consider the fact that last year Congress voted to raise the statutory debt ceiling to accommodate a \$10 trillion national debt. Do you know how much a trillion dollars is? The number is so staggering that it is impossible to comprehend without some frame of reference: A million seconds ago was last week. A billion seconds ago, Richard Nixon resigned the presidency. A trillion seconds ago was 30,000 BC. Our national debt now exceeds \$9 trillion and is escalating even as the population ages.

And while Congress is worried about Social Security, the real problem is Medicare. Social Security represents around a \$5 trillion problem, but when the Baby Boom generation fully reaches the age of 65 — starting less than three years from now in 2011 — the unfunded entitlement in Medicare is estimated to be over \$67 trillion. And we are financing this huge debt by selling securities to China and to other countries still willing to purchase them, not only threatening the fiscal stability of the American government and giving enormous leverage to some of our major international competitors (who at some point may simply refuse to continue underwriting U.S. deficit spending), but also casting a dark cloud of debt over our children's future.

If we fail to address this — if we fail to act boldly — this *will* be our legacy. We have been the major beneficiaries of the investments and sacrifices of the greatest generation and now it is our turn to give back, to ensure that we leave our children not a legacy of debt and degradation but a world of promise and opportunity and hope. How we meet this challenge will be the defining issue of our time. It is the unfinished business of the Baby Boom generation and it is inescapably intertwined with the future of the U.S. health care system. To resolve this crisis, two things are necessary. *First*, we need a shared vision, a set of agreed upon objectives that capture the desired purpose of the U.S. health care system. *Second*, we need an accurate diagnosis of the underlying problem in our current system...

Read the entire article at www.csaq.org/pdf/bulletin/hlthcr_58_4.pdf

What is Congress Up To?

Cynthia Bermann, MD, provides an "Update on Health Care Reform" in the September issue of *Vital Signs*, the journal of The Fresno-Madera and Kern Counties Medical Societies.

The obvious subject this month is "what is the Congress trying to do?" The chimeric and rapidly growing legislation is morphing from providing health insurance for the uninsured to a complete overhaul of how medicine is provided. The proposals are changing so quickly that it is impossible in an editorial to address them in any kind of rational manner. I would like to instead take a step back and ask the following:

If the goal is to cover ten to twenty million absolutely uninsured (as opposed to those between insurance, self-insured, or ineligible for coverage as a foreign national), does it make sense to change the way that the remaining 280-290 million citizens receive their health care?

How can insuring the uninsured take over 1000 pages of legislation?

Why would the government spend a dime (much less the millions of dollars actually being spent) on ADVERTISING to push for passage of a bill that is not even completely written?

Given the failure of German, British, and Canadian experiments in health care, the failure of Tenn-Care and the

Hawaiian health system, why as scientifically based physicians would we support repeating the same experiment?

Would you want to receive care from a health system that Mr. Obama states would be the equivalent of the USPS as compared to FedEx?

Here are the CMA points on WHAT WE MUST HAVE to continue to protect patients and provide excellent health care. Read them, consider them, and tell your elected representatives what they must do to prevent the devolution of health care in the United States of America...

Read more of Dr. Bermann's comments www.fmms.org/index.php?id=148

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