Are we there yet?

By Miriam K. Anand, MD

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Usually the question, "Are we there yet?" is asked with almost an hopeful desperation that the intended destination has, in fact, been reached. Unfortunately, this is not the spirit behind my question.

I have spent much of the year writing about my concerns for how changes in healthcare from a regulatory standpoint would affect our autonomy and ability to provide quality care. As an owner of a private, mostly outpatient, specialty practice, I have certainly felt the pressure of how these regulations have made it increasingly difficult to provide care. I have heard patients complain about how they feel rushed by their other physicians and sympathize with them and their primary care physicians, who I know are forced to limit time with patients. I have heard patients say that their physician no longer makes eye contact with them during the visit and am saddened that I am now one of these physicians as I am required to look at the computer screen to make sure I'm documenting correctly in the EMR and clicking all the right buttons to satisfy Meaningful Use requirements. I am aware that most of us struggle, above all, to provide quality care to our patients, despite the ever increasing obstacles put in our way to do so.

In a mostly outpatient practice, however, I have admittedly lost touch with the hospital-based practice of medicine and mostly have my training from medical school and residency to fall back on when people are telling me about their hospital experiences. Until recently, I thought it a strange coincidence when I was hearing stories of friends and their family members having to complain to administration or patient liaisons regarding their care. Most of the complaints centered around feeling as if they had been treated rudely and dismissively, but some were for medical mistakes and over medication of family members. Unfortunately, experiences close to home with two of my employees have gotten me wondering…has the corporatization of medicine and emphasis on controlling cost caused a compromise in medical care? It is true that there is an ethical dilemma that all physicians face, which is providing appropriate care in the most cost-efficient manner? Have changes such as ACO's, the Medicare "two-midnight" rule, and others pushed the pendulum more towards cost-savings as the first priority?

I first started asking this question after an experience with one of my employees. The lunch hour was finishing when my nurse, with 30 years of experience as an ER nurse, came to me and told me that she had one of our medical assistants (who is 20 years old) lying down in an exam room because he was complaining of palpitations and was ashen and diaphoretic. I went to check on him and found him alert and oriented, but somewhat slow to respond to my questions. His blood pressure was technically low, but given his age and frame, I thought this could be normal for him. I felt his pulse and listened to his heart and he was mildly tachycardic with skipped beats. In getting a history, I found out that he had gone to the Emergency Room at 16 years old for similar symptoms and was told that he should see a Cardiologist and that he might need an ablation. His parents never pursued this and he continued to get periodic short-lived episodes that were less severe. Hoping that this episode would pass, I asked him some further questions and found out that he had not seen his primary care doctor in more than three years. He would thus be considered a new patient there. He also told me that his teacher during his M.A. training told him that he should see a Cardiologist after his fellow students did a practice EKG on him. In the meantime, he still had the palpitations. I started thinking that maybe I should prescribe a beta blocker for him, but wasn't comfortable doing this without the appropriate electrocardiographic studies. We discussed having the nurse drive him to an Urgent Care center two buildings down the street, but when he sat up, he became very dizzy. I then thought that the ER would be the better option, but wasn't comfortable with the liability of having one of my employees drive him there. As a last resort, I opted to call 911, comforted by the fact that he would be taken to the same ER where he went when he was 16 and would presumably be taken directly to an exam room since he would be brought in by paramedics, and would at least be put on a monitor where the rhythm could be seen. By the time they arrived, I had a patient waiting and was already running behind. I went in to see my patient, but had planned to call the ER to let them know the history once I was done. When I came out, my nurse informed me, however, that she had seen some abnormalities on the rhythm strip, so I felt certain that he would get a 12 lead EKG and any appropriate treatment and went in with my next patient. It turns out that he was never even brought to an exam room. He was left to wait in the waiting room for an hour and, by the time he got called back, his palpitations had resolved. No EKG was done and he was told that he probably had an anxiety attack and was discharged with a prescription for a benzodiazepine.

The following day, while working in one of our satellite offices with another physician, he had a similar episode. Knowing about the previous day's events, the physician in that office called his primary care physician to see if they could get him in there, even though he hadn't been seen in a few years. They were very accommodating and after doing a 12 lead EKG, started him on a beta blocker and facilitated an appointment with a Cardiologist for the following day.

Within a week, a second MA was taken by ambulance from her primary care physician's office to another facility (but in the same hospital system) for an incarcerated ventral hernia and an arrhythmia. She ultimately had a laparoscopic repair, that was reportedly difficult, in the late afternoon. I was very surprised to learn that she was discharged home that same evening.

I would have expected that she would have been kept at least overnight to be sure that, at a minimum, she could keep clear liquids down and that her vital signs were normal.

"Stories like these cause me to fear that the answer to my question of, "Are we there yet?" is "yes". We have reached the point where government regulations, pressure to keep costs down and the corporatization of medicine have resulted in decreased quality care and a compromised physician-patient relationship." — Miriam K. Anand, MD

A couple of days after discharge, she was in contact with our Practice Administrator, who told me that she had a fever and was vomiting anything that she tried to ingest. I asked the Practice Administrator to tell her to call the surgeon, fearing an ileus, bowel obstruction or infection. It was a Friday and she apparently never heard back from the surgeon's office. Over the weekend, she continued to have trouble with nausea and vomiting and then also developed chest pain and severe shortness of breath (to the point of not being able to walk to the bathroom). She called the surgeon again and was instructed to return to the emergency department. She did and, between frequent breaths, told them that she was a post-op patient with chest pain and shortness of breath. She was told to wait in the waiting room. During her 40 minutes there, her chest pain became worse and she, and then subsequently her mother, tried to appeal to the clerk to have her seen. They were told that the nurse was aware and they would just have to wait. Her mother expressed concern that the patient might pass out and was told that a code would be called if that happened. Once the nurse finally came, the patient had to walk back to the vitals area and the nurse told her to get on the scale. While trying to get to the scale, the patient became very dizzy due to the walking and had to steady herself on the wall. The nurse told her to hurry up because she had other patients waiting with similar symptoms.

Most readers have hopefully assumed that she had pulmonary emboli. I have admittedly not treated pulmonary emboli since 2001. Perhaps evidence-based medicine has shown that our fears that further clots could break off and cause saddle emboli were unwarranted. Perhaps I am overreacting in thinking that this was a true medical emergency that required more prompt medical attention. (To give some perspective, the hospital in question is a Level IV trauma center and there were four others in the waiting room in the middle of the night, none of whom appeared to be in severe distress.)

I wish that I could say that the remainder of her experience was not so negative. My employee is the single mother of two teenage daughters. As is the unfortunate case with many Americans today, she lives paycheck to paycheck. While in the hospital, the electric company attempted an automatic withdrawal the day before her paycheck was deposited. There were insufficient funds and her electricity was shut off and the food in the refrigerator spoiled. When the case worker came to her on the day of discharge to discuss the cost of her medications with her, she stated that she couldn't afford them because the electricity had been shut off and she had to buy food to feed her children. While the children were being cared for by a relative, the case worker did not ask where the children were and assumed that the patient had left them home alone with no food or electricity. She, the hospitalist and the charge nurse returned to the patient's room and told her that they were notifying the Arizona Department of Child Safety. The patient asked to explain, but the hospitalist told her that his mind was made up and nothing that she would say would change it. Later, with permission from the patient, I spoke to the hospitalist expressing my concerns that he was not getting more information before reporting a meritless case to an overwhelmed government agency, thus wasting tax dollars and time. He was unconcerned, stating that even if it took two to three months for the agency to investigate, he was still going to report it. With attitudes like this, it's no wonder that the former Child Protective Services became overwhelmed with attention detracted from being able to investigate true child abuse and neglect cases.

Stories like these cause me to fear that the answer to my question of, "Are we there yet?" is "yes". We have reached the point where government regulations, pressure to keep costs down and the corporatization of medicine have resulted in decreased quality care and a compromised physician-patient relationship.

The preamble to the American Medical Association's "Principles of Medical Ethics" includes the following: "As a member of this profession, a physician must recognize

responsibility to patients first and foremost, as well as to society, to other health professionals, and to self." The AMA goes on to say that physicians should work to change laws and regulations that interfere with their ability to provide quality care to patients.

Unfortunately, an investigation in 2007 by the AMA found that 15% of surveyed physicians were aware of peer review abuse or misuse. This has been referred to as sham peer review, which has been defined as using the medical peer review process to remove a doctor who is seen to be disruptive or too great an advocate for change. Recall the story of **Dr. Katherine Mitchell**, a second physician to come forward publically about her concerns regarding patient care at the VA. In a written statement, she said, "I have seen what happens to employees who speak up for patient safety and welfare within the system….devastation of professional careers is usually the end result."

Thus, physicians have been bullied into "going with the flow" and not following their ethical obligation to speak up. These factors have contributed to us arriving "there" to the current state of medicine.

It can be very daunting for an individual physician to speak up. This underscores the importance of being a part of organized medicine and a member of the Maricopa County Medical Society. As a reminder the mission of the Maricopa County Medical Society is: "To promote excellence in the quality of care and the health of the community, and to represent and serve its members by acting as a strong, collective physician voice. In fulfilling this Mission, the Society will initiate, respond to, and implement efforts through which professionalism in medicine is enhanced; the ethics of medicine are fostered and preserved; the patient's rights and choice are supported; and quality practice of medicine is preserved."

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