

From the President: Pushing Sisyphus's Stone in Healthcare Hades

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Twenty years ago, when I received my acceptance letter to medical school, the first thing I did was to call our family doctor and friend, Dr. Nelson, to tell him the news. He congratulated me, but also gave me a grave warning that I still think about frequently:

"I want you to think long and hard before you accept entry into medical school. Being a doctor means making lots of sacrifices. It means putting others before yourself and sometimes even before your family.

"It means sleepless nights, taking care of people who have been careless with themselves. It means you may miss your children's first steps, first words, and Christmas plays because illness doesn't take a break or respect families or holidays. It means you will battle death on a daily basis, and sometimes you will delay it, but other times you will lose resoundingly. Some of these losses will break your heart and make you a much different person than you are now. You will see horrors as terrible as war and get no medals for doing so.

"But if you choose to accept that letter, you will be taking on the noblest job in the world. You will get to do on a daily basis things that would be profound to most men if they only happened once in a lifetime. You will get to hold life in your hands as it begins and see the miraculous, as the soul rushes into a pink squirming infant. You will have the honor of holding an elderly lady's wrinkled hand as the angels come to take her home.

"I have done all these things and so much more and so can you. So think long and hard before you accept that challenge, because it is a difficult, valiant job that only a rare few can really do and even fewer can do well."

I have never regretted my choice to accept that responsibility, although all of the warnings Dr. Nelson told me about have become a reality.

Twenty years later, much has changed in medicine. The nobility is being squeezed out of our profession and replaced by rules, paperwork, fees, and meaningless tasks.

Lately I feel like Sisyphus in Hades rolling the immense boulder of rules and regulations up a hill, just to have it come crashing back down on me, over and over. I want to take care of people, I am willing to sacrifice, but I do not want to sacrifice my life to pointless paperwork and relentless regulations.

The Mockery of Maintenance of Certification

When I first decided to become a pediatrician and internist, maintenance of pediatric board certification required completion

of a take-home test. It was meant to challenge, but even more to teach the pediatrician new developments and changes in our field. As for internal medicine, it was known that the initial board was difficult, but once you were board certified, you were certified for life. All doctors were required to take continuing medical education (CME) as they are today. Board certification was an academic honor to maintain and a source of pride.

Now Maintenance of Certification (MOC) is a billion-dollar industry. Board entities falsely suggest that physicians no longer care about their patients enough to stay up to date and therefore require oversight. They insist on ridiculous and expensive exercises to maintain board certification. Application for the MOC process costs more than \$1,300.¹ Review courses cost approximately \$1,100, and the study books cost another \$800.² These resources are not optional because the test covers many aspects of practice that are only performed by specialists.

Then the physician must take on-line CME tests over materials that are acknowledged by the internal medicine board to be up to 3 years out of date, but still are somehow deemed necessary. After each of these online tests, a survey asks for the physician's opinion of the test.

The next requirement is a two-hour-long survey asking explicit details about the physician's practice. (There is no follow up, feedback, or grade given for this. I am assuming it is all "information gathering" for the board.) According to American Board of Internal Medicine's (ABIM) Privacy Policy, you have no privacy, since "ABIM and third parties may use your private information to offer you additional information, products or services that match your areas of interest." In other words, they are selling physician's contact and personal information to marketers to make even more money.¹

The next mandatory exercise on the long road to "recertification" is the newly concocted "Practice Improvement Module," which asks the applicant to "evaluate your practice" in one of two ways: a colleague (or competitor) is asked to judge the physician with a series of labor-intensive questionnaires, or the applicant must hand out patient surveys in which patients are asked to grade the physician, both clinically and from a customer service standpoint. All data must be collected, reviewed, and coded by the physician and submitted to the board's online data collection program. After this, the physician must tell the board how the survey results prompted improvements and what changes to the practice will be made. Finally, a second round of surveys must be sent out, scored, tabulated, and submitted to measure any improvement.

After the physician dutifully accomplishes all these tasks, he is required to sit at a computer for 6 to 8 hours and take the actual test—without ever being told what is on this test or what to study. (In fact, physicians who have told others what to study for the test have been sued and even lost their licenses.) On test day, the doctor will be fingerprinted or have his palm veins scanned and be treated like a dangerous criminal while taking the test. The physician is denied food or drink, may not have any personal items, including a common wristwatch, or be in possession of a pen or pencil. The doctor is recorded on video and audio throughout the testing.

Even though each person is installed in a private cubicle, I was admonished for “not sitting properly,” as I had elevated my recently broken foot, and was threatened with ejection. I believe the prison system treats convicts with more trust.

Two months later the results are returned, simply “pass” or “fail” without any opportunity for feedback or learning. Later, a comparative score is given so that the physician sees how he compares to other board certified doctors who took this particular exam.

If the doctor questions this score, his only recourse is to pay another \$250 to the board to have it re-graded! At no point does the physician have the opportunity to see which questions were marked incorrect. At no point does the physician have an opportunity to learn by reviewing his test.

In addition to the high up-front cost and a testing process that does not allow for learning or improvement, and that provides no clear evidence that physicians are better for participating, the MOC process takes a great deal of time away from patient care. These exercises do not make for better physicians. It is time to walk away from them.

One becomes a better physician by taking care of patients. The MOC only takes doctors away from their patients. In my small town, it can be very difficult for my patients if I am away from my office. It costs me and my patients more than just loss of time and money. I am not afraid to say that I am important to my patients and they are more important to me than the MOC.

The Error of the Electronic Health Record

Electronic Health Records (EHRs) put yet another barrier between patients and their doctor, and make it more difficult for the doctor to fight on behalf of his patient. They also make it far too easy for a physician to commit fraud, even accidentally.

One of the most tragic events in my medical school career was when one of the other students was expelled for producing fraudulent medical records. He had written a brief SOAP note on a post-delivery patient who spoke only Spanish, which he did not understand. He was immediately dismissed from medicine, never to be able to return again, and rightfully so.

The practice of medicine relies on physicians being thorough and honest. Why has this been discarded with the advent of electronic medical records?

With automatic templates, I get referral notes on a daily basis that have templates that are not accurate about my patients. I have a five-year-old patient who is severely asthmatic. Her note from the ear-nose-and-throat consultant says that she “drinks alcohol occasionally and is contemplative about quitting.” I can attest that this sweet little girl does not drink alcohol. I am fairly certain that this was the social history on the ENT specialist’s previous patient. Nevertheless, this is now a part of her permanent medical record. Her insurance company has access to this, and it could result in higher insurance premiums for her in the future, with her parents none the wiser.

This may have been an honest mistake, but there are many more of these types of mistakes happening regularly now that doctors are “right clicking” instead of actually writing notes.

When my daughter broke her little finger, she saw a physician assistant who did not even have a stethoscope. When I got a copy of her note, it showed that there was a full physical examination. The insurance company was charged for a new patient level-4 exam (which requires a full body exam). So, was this a mistake, or was it fraud? Either way, honest and dishonest practitioners are violating one of the most sacred aspects of medicine: being careful and honest with a patient’s most important information.

The EHR, instead of being the much-touted tool for efficiency is often the opposite; inaccurate patient data snowballs, as entire charts are forwarded with each referral or record request. The doctor, buried in an avalanche of data with no way to know what is factual or template-generated, is still held to the standard of perfection, and anything in this file can be used against him if the patient has a bad outcome.

EHRs’ robotic nature and the “simplicity” they promise may actually be turning your patients into something they are not.

Code Blue for the ICD Codes

Another way the medical bureaucracy is placing a wedge between the patient and doctor is with ICD codes. By forcing doctors to interpret patients as code numbers, the personal aspect of the patient-doctor relationship is reduced to numbers. In residency, we were admonished if we referred to a patient as “that diabetic in room 203.” We were told that to address patients as illnesses was to remove their humanity. Now it is not only condoned; it is required!

This year, the updated International Classification of Diseases (ICD-10) codes will take effect. On its website the American Medical Association states, “ICD-10 codes have fundamental changes in structure and concepts that make them very different from ICD-9.” Physicians will need to take time away from patient care (and board review), to go utilize the new code book that is 1,600 pages long.³ Current Procedural Terminology (CPT) codes have also expanded. This is the way the AMA obtains money and power in a corrupt system, and steals time and resources from the physician. Currently AMA is said to make about \$70 million per year “licensing” these CPT codes, and it does not allow for free or

open distribution of these required codes. It has a monopoly under a secret pact the AMA made with the government in 1983.⁴

The ICD-10 codes will take the number of codes from 3,000 to 87,000. The purpose is supposedly to reduce fraud, but the system is actually a way to make the physician's job much more onerous. As if keeping up with medicine were not a big enough responsibility, now we must differentiate between codes for a Macaw verses a parrot bite. There is a code for "bit by a turtle." There is even a code for "burned while on water skis."⁵ I researched this last one and could find not a single case of a patient being burned while on water skis. Why does this code even exist?

I already find it difficult to assign a proper code for a patient encounter when I am trying to discern what malady they have. "Early morning headache" is not a code, nor is "possible brain tumor." Will the codes actually decrease fraud, or just make it easier for insurers to refuse to pay for tests? Will they make it easier for doctors to be accused of fraud in an overwhelming system that insists on reducing all patients to numbers?

Getting Back to Patients

We must all remember why we went into medicine. Was it to roll over for these government bureaucrats, or to serve the sick and comfort the ill? Our job requires us to give up a great deal, and

I gladly give it up to serve my patients, but I do not see how patients are served by my filling out surveys, using a computer instead of a pen, or turning patients into code numbers.

Let's remember what is important: the patient and the patient-doctor relationship. We must make our voices heard and improve patient care by refusing to get involved with MOC, making certain our records are true and private even if that means using a pen and paper, and withdrawing from government systems that dictate how we must practice medicine. We must continue to put the patients first and fight for what is right.

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