

# Physicians Must Learn from History, or Become Its Victims

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On March 22, 1775, in a speech urging conciliation with Britain's American colonies, Edmund Burke stated that whereas in other countries people "...judge of an ill principle in government only by an actual grievance," Americans "anticipate the evil, and judge of the pressure of the grievance by the badness of the principle. They augur misgovernment at a distance and snuff the approach of tyranny in every tainted breeze."<sup>1</sup>

Likewise, James Madison adjured that:

It is proper to take alarm at the first experiment on our liberties. We hold this prudent jealousy to be the first duty of Citizens, and one of the noblest characteristics of the late Revolution. The free men of America did not wait till usurped power had strengthened itself by exercise, and entangled the question in precedents. They saw all the consequences in the principle, and they avoided the consequences by denying the principle. We revere this lesson too much soon to forget it.<sup>2</sup>

The major reason tyranny is overtaking us is that we have not taken alarm or action at assaults on our liberties. The short human lifespan makes transmission of salient history to succeeding generations a matter of great urgency. The generations of physicians now alive, from medical students to the retired physicians, should have snuffed the closer and closer approach of tyranny in every tainted breeze, and acted to nullify it.

## Danger Looms, Including for the "Entitled" Groups

A second reason people wait until tyranny closes in is the seduction of easy gain. The AMA opposed Medicare and its antecedents in the Social Security bill. It went through anyway, and then, when physicians realized that payment through government would make it easier to deal with people who never paid their bills, they signed on with Medicare and Medicaid. Physicians did not count on the government defaulting on paying for thousands of patients. They did not follow the logical consequences, and now the unconstitutional provision has strengthened itself by exercise, and entangled the question in precedents.

Even for people, including elderly patients, who have clear memories of the days before 1965 it is as though we had never done fine without Medicare. There was no crisis when President Lyndon Johnson foisted this system on us.

Anyone reflecting on Medicare and Medicaid, and also reflecting on immutable human nature, could see clearly that Medicare and Medicaid would lead to disaster. In effect, Medicare and Medicaid give full discretion to certain classes of citizen to spend other people's money. Taxpayers' money is not money the government has "asked" taxpayers to "contribute"; they have been forced to do so. Medicare and Medicaid are not a "compact between generations." They are simply forced transfers between

those who are made second-class citizens by being forced to pay others' bills, and the people who are passive receivers of this largesse. Those who receive it have had no problems; the government has not accused them of waste, fraud, or abuse, because they are a large group of bought votes.

Occasionally, when there is talk of doing something to prevent these programs from bankrupting our nation, we hear protests from people demanding that what they term "their" Medicare be left alone, since they paid into it. But both programs are Ponzi schemes that make Bernie Madoff look like a petty thief. Only people who are 66 or younger in 2011 have paid in to Medicare since they were 20, an arbitrary start of the working age, or for 46 years. A person 86 now paid in for only 26 years, if he retired at age 66; he did not start paying in until age 40. He is likely to have cost the taxpayers far more than he ever paid in Medicare taxes, which are taxes, not "contributions." Younger working taxpayers are paying the bulk of the Medicare bills.

Now, those on Medicare and Medicaid are facing what was entirely predictable; namely, having the government decide whether it is "cost-effective" to treat them for their medical concerns. These decisions, if "Affordable Care Act" (ObamaCare) measures continue to roll out without repeal or amendment, will be made by unelected bureaucrats in the Department of Health and Human Services, not by patients and families in conjunction with their physicians. In effect, since they are dependent on government for their medical care, the government owns them; they are like livestock on a government ranch.

## How Are Physicians Faring?

In the 1950s not much could be done for President Eisenhower's heart attack except for 7 weeks of bed rest and Coumadin. There was no such thing as a coronary bypass or stent. By the mid-1960s things had improved dramatically. Medical care was at the beginning of a gigantic historical revolution, in basic medical knowledge and molecular biology, in surgical techniques for a wide range of disorders, the technology to support those techniques, and pharmaceutical methods of treatment for cardiac, mental, arthritic, respiratory, infectious, gastroenterologic, and other diseases.

When Medicare and Medicaid started in 1965, physicians were a mostly autonomous group. They practiced mostly in solo and small group practices. They went through rigorous training, and remained the most trusted group in America.

There was a lag period, but government interference since then has done much to destroy medical practice and the morale of physicians. The pernicious effects are accelerating. Increasingly, in the last few decades, we have witnessed the encroaching stranglehold of the government-industrial complex on the practice of medicine. Some changes have been drastic; others

incremental. To recognize slow change requires more vigilance than to notice rapid change. Physicians have traditionally worked long hours, which does not leave much time for reflecting on the effects of the toxic changes imposed by government. Government and third parties imposing those harmful changes do not do any of the actual work of patient care.

### **Emergence of the “Disruptive Physician” Label**

Various organizations have voiced concern and come up with plans for a problem we did not hear much about until recently, namely “disruptive behavior” in hospitals. It is said that this was not addressed in the past because the disruptive physicians were politically connected, or high revenue producers. However, I am not aware of any actual longitudinal studies showing that that is anything more than conjecture. Also, in the past, physicians produced high revenues not as employees of hospitals, but as autonomous entities who sometimes admitted patients to hospitals, and did not need to be “politically connected” within a hospital, because hospitals functioned more as places for sick patients to be taken care of until they were well enough to be discharged, and less as businesses.

Demonizing people is a common totalitarian tactic.

The most common form of what is termed “disruptive behavior” is said to be bullying, which is “subordinates’ perception of the extent to which supervisors engage in the sustained display of hostile verbal and non-verbal behavior, excluding physical contact.”<sup>3</sup> Bullying would be a problem in any venue. However the literature is rife with words such as “suggest,” “perception,” “satisfaction,” and “link.” It is said that as a consequence of bullying “[a]t best, work is not as exhilarating as it could be. In the worst-case scenario, working becomes filled with anxiety.”<sup>3</sup> Medical practice is already filled with anxiety over how a patient will do before, during, and after surgery, or with medication, or with any other action designed to benefit the patient and prevent death, pain, impairment, and disease. Now, anxiety in physicians is increased by drastic and constant changes and demands for uncompensated work and compliance with non-funded government mandates.

“Culture” in the hospital is often cited as a contributing factor in disruptive behavior.<sup>4</sup> The Center for American Nurses in 2007 published a booklet *Bullying in the Workplace: Reversing a Culture*. For those of us who have spent more than 20 years in hospitals, this is ludicrous. Human relations never will be perfect, but to describe hospitals as a culture of bullying simply makes no sense.

“Disrespect” is called the most common disruptive behavior.<sup>5</sup> Some of the disruptive behaviors often cited are physicians throwing charts, and nurses belittling less experienced nurses. However, “[s]ubtle intimidation is more common than overt threatening behavior.”<sup>6,7</sup> In other words, condescending language or intonation, impatience with questions, or reluctance or refusal to answer questions or phone calls constitutes disrespect. A lot of this is vague, undefined, and very much dependent on the psychological makeup of the beholder. None of it addresses the fact that the physician, as the person ultimately held responsible for the patient, must demand proper performance from other people.

Namie states that 80 percent of all targets of disruptive behavior are women.<sup>8</sup> There is no doubt that women have had difficulties dealing with men in the workplace, owing to various aspects of common male behavior; yet, there remains an elusive quality to these statistics. Personal perceptions often have antecedents in a person’s life that may predispose to less emotional sturdiness than the hospital environment requires.

The women’s movement in the last few decades has focused much needed attention on ways in which women were relegated to what men considered women’s venues, and much has changed for the better in that regard. It has not been as much remarked that the recognition of ways in which women were marginalized can lead to an unfocused feeling of deprivation that does not always square with reality in a given situation.

Hospital administrators are advised to “...design an organizational approach to promoting a work environment that is psychologically and physiologically safe and that enables staff to focus on delivering high-quality, cost-effective, and satisfying care.”<sup>6,7</sup> These formulations always seem to have managers and administrators who do not do any of the actual work of patient care, leading the rest of us along, but exempting themselves, as though they were in charge of a bunch of unruly kindergartners.

Vanderbilt University has a course for “Disruptive (Distressed) Physicians,” which is described by their center as “an emerging issue.” It is for physicians expressing rage or uncontrolled frustration, although doubt, fear, sadness, and ambiguity are invoked also. The goal is to teach physicians “new behavioral skills to enable them to function in an increasingly complex medical environment.”<sup>9</sup> Maybe a new environment without the loss of freedom to government dictates would be a better idea.

### **Increasing Complexity and Uncertainty**

The tremendous advances in knowledge, techniques, technology, and pharmaceuticals have certainly made medical practice much more complex. Even with long hours, it was much easier to be a physician when there was not as much to know and to learn as there is now.

Lawyers can extort millions from innocent physicians by playing to a jury’s emotions. That increasing threat has also contributed to the stress and uncertainty felt by physicians in this ever more complex environment. Medical care deals with individual human beings, each one with a different personality and emotions, different set of medical problems, different genetic endowment, and different life experiences, including occupation and diet. Patients cannot be treated as if they are pieces stamped out of sheet metal. Government and lawyers seem unaware of these complexities.

One source of increasing complexity that seems seldom considered as a cause of physicians’ distress is the constant drastic and incremental changes imposed from without, and deriving from government interference in medical care. No place in our Constitution is there any warrant for government involvement or interference in medical care. Nothing is more personal, or less conducive to government direction, than medical care. Unfortunately, physicians are inducted into Medicare and Medicaid

without their consent, just as soon as they begin their internships, by residency programs, which all operate within that system.

Since there are far fewer physicians than patients, when the Medicare and Medicaid systems began to mushroom into the money-gobbling behemoths they are, government made physicians the fall guys. We are supposed to tell the patients that they can't have the cosmetic procedures they think they are entitled to have, or the things not covered under Local Medical Review Policies, which are now termed Local Coverage Determinations. We are the ones required to obtain signatures on Advance Beneficiary Notices, after explaining the whole thing, and their options, to the patients.

### **DRGs and Explosion of Codes**

In the 1980s the government instituted a new system of payment for Medicare and Medicaid "beneficiaries" called the "Diagnosis Related Groups" system. Now hospitals were paid according to the listed major diagnosis, and secondary diagnoses, instead of according to the actual cost of hospitalization. This is analogous to paying a lawyer a flat fee for "murder defense," "armed robbery defense," or "RICO defense" instead of according to the sacrosanct "billable hours." But of course, we do not have "Lawcare" because lawyers are overwhelmingly the largest group in government. DRGs caused more complicated coding and a rush to discharge patients from the hospital as quickly as possible. Physicians were distracted from their major concern, namely, taking care of sick people, in order to deal with ramifications of this new policy.

Physicians have had to cope with other major changes in the last 25 years—changes unsought by physicians but promulgated by third parties who have nothing to do with actual patient care. Those changes include coding, first with ICD 9 (15,000 codes), and now with ICD 10 (68,000 diagnostic codes), and also with CPT (Current Procedural Terminology). Everything diagnosed and performed in an office or hospital must have the proper code found and appended to it, for third-party payers' convenience.

The Correct Coding Initiative became operative on Jan 1, 1996, "to promote national correct coding methodologies and to control improper coding." Yes, there is a policy manual, full of arcane abbreviations, and the same style of language that befuddles the income tax-paying half of the population in IRS publications. There are courses, and workshops, to teach physicians and "professional coders" the intricacies of coding, but the physician is liable for mistakes, so a mistake in choosing the proper code can mean criminal prosecution. Codes are changed, and doctors must buy new code books, as big as telephone books, with the new codes arranged in what seems to be a haphazard way.

### **RBRVS: Government Price-Fixing and Bullet Points**

The Resource-Based Relative Value Scale attempts to put a value on physicians' services—a value to the third-party payers, not to the patient. Formulas were devised and are constantly revised, in a fruitless attempt to figure out how much effort and other resources go into each service performed by a physician. Payment by the third party is based on that formula.

The Evaluation and Management codes present a maze of bullet points in the history of 1-2, or 3 chronic conditions, with the history being brief or extended, that is with 1-3 or more than 3 factors, the review of systems mentioning 1, 2-9, or more than 9 systems, and the past, family, and social history being not applicable, or with 1 or more areas. Then there is the physical examination (read on), and then the choice of guidelines either from 1995 or 1997. Are you able to follow this?

The exam can be limited to just one affected system, or limited to one plus another related system, or an extended exam of the affected and other related organ systems, or it can be a general multi-system exam, or a complete single organ system exam. Do you understand? Let me catch my breath.

There are of course, accompanying numbers for exactitude; 1, or 2-7, or 8 or more "body areas and/or organ systems" for the 1995 guidelines, and 1-5 "bulleted elements", 6-11, 12-17 for two or more systems, or 18 or more for 9 or more systems in the 1997 guidelines.

Then there's the "medical decision-making" portion. That can be minimal, low, moderate, or high. The physician is supposed to count up the total numbers at each step, and an overall total number of points. I'll stop here. That's enough!

Is this what you want your physician to be thinking about while you are explaining your problem, or being examined? Talk about being a number! It's a maze of infinitely wearying booby-traps for the physician, and it reduces the patient to "bullet points."

### **Laws Beget More Wasteful Bureaucracy**

HIPAA, the Health Insurance Portability and Accountability Act, a monstrosity from senators Ted Kennedy and Nancy Kassebaum, diverted attention from medical care itself, to providing meaningless HIPAA notices to everyone, reconfiguring office traffic, wasting money printing brochures, and training and appointing "compliance officers." It does not protect your privacy from the government, banks, insurance companies, or law enforcement. The devilish part lies in the fine print.

### **EHR: Interoperable Chaos**

The electronic health record (EHR), in its guise as "interoperable," is being imposed on physicians through monetary bribes. "Interoperable" means that medical records can be instantly transmitted out over the Internet, examined by the government, and parsed down to the quick to discover the cheapest way for the government to control medical care. Using the EHR allows government to treat people as groups, rather than as individuals. Physicians are being bribed with \$44,000 to "implement" it, which in itself shows that it is very valuable to the government. In practice, the EHR, with its dizzying array of icons, its counter-intuitive headings, subsets and arrows, frustrating and wearying to deal with, imposes a barrier between physician and patient. It is an obstacle rather than an aid. It is a safety problem in that one mistaken keystroke can fill the record with mistakes, and an obstacle in that its complexity prevents the physician from completing the simplest task without the mastery of yet another system.

## Medicare Program Typifies Fraud, Waste, and Abuse

Local Medical Review Policies, now termed Local Coverage Determinations, confuse both physician and patients, who are told Medicare will not cover something in Florida that was covered in Connecticut.

The big waste-fraud-and-abuse witch-hunt fails to find the major fraudster, the government, which has foisted a Ponzi scheme onto every young working person in the nation.

“ObamaCare” includes a capitation-like provision, Accountable Care Organizations, where there will be no accountability to the patients, or to the physicians. Everyone will be accountable to the government, in case it costs more to take care of you than the government wants to spend on you. It means only more frustration, confusion, and bureaucracy. A few people are gamely looking into it, but others have said flatly that it is just too much, and they will not do it. There were at first 65 new checkpoints to distract the physician, now reduced to 33.

## Patients Are Not Widgets; Physicians Are Not Puppets

Not even *The Wall Street Journal* seems to comprehend the problem. Laura Landro, who moderates a task force discussion on “Health Care: Change the Incentives,”<sup>10</sup> wonders, “How can companies and governments keep costs down and improve the quality of care?” Landro starts by saying that since “ObamaCare” is here to stay, we need to “work within the system. The industry needs to work with government and try to change some of the ways that health care is structured right now, change the way it’s delivered, and change the incentives for employers, physicians and consumers.” Note that physicians seem to just be puppets, in her formulation.

Then Angela Braly, a lawyer and CEO of Wellpoint, who was paid more than \$13 million in compensation in 2009, states, “[R]ight now we have a fee-for-service payment system, so we pay for quantity rather than quality. And very importantly, we think we need to redesign the way in which we reimburse for health care.” She suggests that “reimbursement could come in the form of accountable care organizations or patient-centered medical homes, or pay-for-performance or risk sharing.... [W]e didn’t want to be completely prescriptive in terms of what that reimbursement formula would be.” “We” means Angela Braly and who else?

Klaus Kleinfeld, chairman and CEO of Alcoa, was also a panelist. In an apparent attempt to apply the principles of aluminum can manufacturing to medical care, Kleinfeld states:

If I were to look at a set of factories that make the same thing, and one does it in five days, and the other one in 10 days, and the one that does it in five days is cheaper than the one that does it in 10 days, why would I not bring everybody down to the five days?

So the question is, what hinders the health-care industry from applying the same mechanics? There was agreement that today for every important disease category there are also quality indicators that are accepted that you could use to see what is the quality delivered.

Once you control the process, once you bring the quality up, the costs go down.

To Kleinfeld, patients and the medical are abstract concepts. He has never taken care of patients, and has no idea of the

complexity of dealing with the frail elderly, scared children, or of the multitude of other factors that may bear on just one condition. To him, patients seem to be like soda cans.

## We Must Restore Freedom

In colonial America, the colonists found themselves in a thinly populated continent with the main body of the state across the Atlantic Ocean. Until the 20<sup>th</sup> century, the state lacked technical means of oppression, which it now has. During the 20<sup>th</sup> century, our government has learned more from tyrannies than tyrannies learned from us. However, during the first century and a quarter of our nation’s existence, we were relatively free.

Our legacy was freedom, and there were few laws. If someone wanted to open a business, the only requirement concerned whatever was physically necessary to carry on whatever type of business it might be. The pre-United States was a wilderness. Even if we date our nation’s origin arbitrarily to as early as 1600, in 350 years our inventions, discoveries, and advances had surpassed those of every other nation in transport, energy, agriculture, mining, science, manufacturing, and medicine.

Those in the government-industrial complex do not know anything about medical care. They cannot imagine that medical care in this nation developed without their prescriptives, and that it has been far more innovative and effective than Wellpoint, right up to the point at which government-industrial folly started tripping it up. They seem oblivious to the cultural changes—sexual debauchery, “recreational” drug use, and other cultural maladies, which are the patients’ responsibilities, not the physicians’.

The major incentive for me is to get out of the government-industrial complex, and to practice medicine without interference from Wellpoint, Alcoa, or the government, the way my veterinarians do, which has allowed my dogs to live well into their teens, in peace and freedom.

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