
EDITORIAL

What's wrong with the practice of medicine today?

As *health care reform*, or should we say *health care insurance reform* moves forward, many practices, small and large, are struggling. Many physicians are leaving private practice for the “security” of a hospital or large group, with others opting out of insurance. Burnout is rising amongst US physicians and ranks at the top compared to other workers. Factors associated with burnout are loss of autonomy and excessive bureaucracy, both central to physicians and health care reform. The practice of medicine is being forever changed by forces mostly outside of the profession and the patient provider interface. As noted by medical ethicist Dr. Arthur Kaplan: “The...aging population, pressure to contain costs, and accountability to third parties are forcing physicians to move away from their exclusive role as patient advocates...”. What are the other factors impacting the practice of medicine that divert attention from patient care?

Practices must deal with uncertainty on how insurance carriers will pay for medical care. The fee-for-service model is decades old. However, the Department of Health and Human Services (HHS) is aiming to have 90% of provider payments based on value or quality by 2018. Sadly, it is nearly impossible to measure outcomes for most of the care that Medicare beneficiaries receive. Proponents of the radical change in the way physicians are paid say that fee-for-service encourages overuse and provides incentives to focus on the volume of care rather than quality. One HHS metric for quality is readmission data. A recent large analysis has shown that this metric is a poor surrogate of quality of care, yet it persists.

Physicians are also impacted in the face of declining reimbursements, increasing costs and government mandates to practice medicine. It is very discouraging to have major health insurance companies with soaring stock values increasing payouts to their investors while many practices are unable to keep their doors open.

Low physician payments are now at the Supreme Court where an Idaho group is suing for inadequate payments for Medicaid services. Medicaid rates are often below the cost to deliver care. A health care safety net for poor families is needed but should not risk the viability of practices and their employees, creating a moral conflict. Concerning moral conflict, last year an insurance company began to offer incentives to oncologists who followed the company's treatment regimens, treatments that may or may not be consistent with national standards but have the “noble” intention of reducing unwarranted variation in care and cost.

While the ever present fear of the plaintiff's attorneys persists, new breeds of consultants are now regularly frightening physicians. “Incident to billing” is highlighted as a target in the Office of Inspector General that physicians need help with. Hying CMS audit fears due to incorrect documentation, and billing for mid-level providers is another reason you need a consultant's course. Physicians should fear “Modifier 59”, a commonly used coding modifier that seminar consultants tell you is being misused and abused. Another popular course is teaching physicians on how to avoid “negative payment adjustments”, ironically run by CMS and their “Medicare Learning Network”. Physician threats even include words from President Obama's former national coordinator for health information technology concerning physicians adopting electronic health records stating “...the threat of penalties is the only incentive (doctors) have to make it happen.”

The visibility of physicians make them easily accountable for rising health care costs when in actuality they have relatively little control. The high expenses of developing new technologies, novel medications, cost of regulations and an increasingly elderly population do not seem to be items that physicians control. Are physician's salaries causing the high costs of health care? Numerous organizations have calculated that after school related debt, training, the overhead of practice and the typical work week, lifetime physician compensation on average ranges from \$60-\$90 an hour. CMS recently released physician claims data, without context subject to inaccuracies, misinterpretation and false conclusions on the part of the public. This contributes in part to the declining trust of US physicians, currently lower than other benchmark nations.

Nearly every day we hear about the health care crisis in America and demands for health care reform. The government and a plethora of third parties are offering solutions for the crisis. According to the NCI from 2000-2009, cancer mortality fell by 1.8% and 1.4% annually among men and women respectively and by 1.8% a year in children. Specifically, between 1990 and 2011 breast cancer deaths are down 34% and prostate cancer deaths down by nearly 50%. Infant mortality declined by 12% in the US from 2005 to 2011. All these occurring before our current “reforms”.

Maybe there is something good to say about the practice of medicine today.

Leonard G. Gomella, MD
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Laparoscopic Urology Fellowship

McMaster Institute of Urology at St. Joseph's Healthcare, Hamilton, ON

We are currently accepting applications for the **2016-2017** year Laparoscopic Urology Fellowship Program. This Fellowship is open to Canadian urology graduates. The fellow will have the opportunity to work with 5 laparoscopically trained urologists at St. Joseph's Hospital in Hamilton. Over 300 laparoscopic and robotic cases were performed last year at our centre. They will have exposure to basic, advanced and robotic laparoscopic urologic surgery including: laparoscopic pyeloplasty, donor nephrectomies, partial nephrectomies, prostatectomies, adrenalectomies, lymph node dissections and ablative technologies. A protected research time is provided for the fellow. **Current PGY-4's** interested in this fellowship program should send a cover letter, CV and 2-3 references directly to Dr. Edward Matsumoto urology laparoscopic fellowship director.

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