

Reflections on the Destruction of American Medicine

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I look at my watch: 1:00 a.m. Hastily, I report to pre-op holding. Upon opening the hospital electronic health record, the emergency room chart ominously had a patient arriving with unstable angina and in sepsis, the highest ICD-10 codes populating the problem list, with mandatory algorithms being implemented.

Given that little is communicated accurately, and worse, knowing the rampant fictionalization of patient care and the shameless up-coding by EPIC hospital computers, my only thought was that I would have to wait and see what the truth really was.

Fortunately, the patient who arrived with a perforated appendix was quite stable, though dehydrated because of third-spacing of fluid. All that was needed was intravenous fluid and routine lab tests. It was an easy laparoscopic appendectomy. The unstable angina of course did not exist, but it added a nice code to the active problem list.

With the patient in the operating room, my attention had to focus on EPIC: the agonizingly slow process of logging in, then entering charges for the hospital and patient data while simultaneously administering a rapid-sequence induction, with alarms sounding. I thought this must be akin to a jet pilot taking off while texting in bad weather at 1 a.m.

I am called a pain doctor—a member of the specialty that politicians blame for the “opioid crisis.” The word “opioid” is misused to generically include all illicit substances of abuse. What we really have is a substance-abuse crisis. Opioids are only one type of many dangerous substances.

My humble career began with an internship in general surgery (an intense trauma program), followed by an anesthesia residency. I received a subspecialty certification from the American Board of Medical Specialties (ABMS) in pain medicine, maintained through the appalling time-consuming and costly Maintenance of Certification (MOC) process, which means little to nothing. I also completed a fellowship in the World Institute of Pain and a separate fellowship through the American Board of Interventional Pain Practice, and I am a Fellow of Interventional Pain Practice. These all lack significant recognition or commensurate remuneration. In addition, I have contributed to my specialty by coauthoring articles on topics important to controlled-substance use as well as on the risk of spine interventions with concurrent anti-thrombotic therapies.

Practicing independently for the last 35 years in a semi-rural area of western Arkansas, I have experienced the best and the worst of times, mostly worse lately. I run my own solo interventional and diagnostic spine clinic during the week, with 12-to-14 hour days, of which a third of my time is devoted to useless federal data entry and charting. One weekend per month I contract to continue anesthesia coverage for 50 hours because of chronic physician shortages. I'm phasing out complex interventional spine surgery, as the operating-room

culture of poor quality remains unaddressed. I find myself the only one left performing traditional hand scrubbing, following strict sterile protocols. The surgeons lost stature and authority long ago, and hospital staff felt this aspect of sterile technique was not cost-effective.

In this new era, the progressive element of the hospital administration considers that an anesthesia practice based on certified registered nurse anesthetists (CRNAs) is superior to a physician practice. However, to provide legal coverage, I was kept on, and was sometimes even able to offer an anesthesia suggestion, typically quite unwelcome. If I asked any one of the CRNAs what the alveolar air equation was, and why it was of the utmost physiologic importance to anesthesia, I have gotten looks of puzzlement. I was to be seen and not heard.

I recently read *The Death of Expertise* by Tom Nichols. It's a great read. He has a lot to say about our new normal. Though the book touches on medicine only briefly, his thesis is very poignant. The current conceit is that if one can “Google” “facts” on any subject, surely one must know as much as the professional does, in fact more. Facts are the same as knowledge, right? Disagreement, of course, is always considered a personal insult, so one must be very careful with one's opinion, or suggestion, even or especially when a patient is turning blue.

Differential Diagnosis

The *Los Angeles Times* recently ran an article claiming that “U.S. health system costs four times more to run than Canada's single-payer system.” The opening paragraph says it all: “In the United States, a legion of administrative healthcare workers and health insurance employees who play no direct role in providing patient care costs every American man, woman and child an average of \$2,497 per year.”¹

The article states that: “Across the border in Canada, where a single-payer system has been in place since 1962, the cost of administering healthcare is just \$551 per person—less than a quarter as much.”¹

Administration absorbs 17% of Canada's national expenditures on health. In contrast, “in the United States, twice as much—34%—goes to the salaries, marketing budgets, and computers of administrators in hospitals, nursing homes, and private practices. It goes to executive pay packages which, for five major healthcare insurers, reach close to \$20 million or more a year. And it goes to the rising profits demanded by shareholders.”¹

The Elizabeth Warrens of the world see Canada's single-payer system as the answer. Few understand the real reason for declining quality and value in our medical system. One reason is the misuse of coding.

ICD-10, a 1990 product of the World Health Organization (WHO), was forced on us by the Obama Administration after

its near-disastrous introduction in Canada and elsewhere. Its implementation was expensive, of questionable purpose and benefit, and ripe for exploitation. It was the perfect vehicle for the new “healthcare” cartel.

My 1 a.m. case was a good example. Patients are so up-coded with inaccurate ICD-10 descriptors and disease codes justifying trips to the imaging suite that medical costs can only go up, never down. Patients are moved from one profit center of the hospital to the next. Computerized tomography and magnetic resonance imaging devices run at all hours in the circle of employed physician/midlevel clinics, in a continuous, dizzying carousel of ever increasing ICD-10 codes. These codes are confusing and often fictional to such an extent that as hospitalists come and go through shift changes, more often than not no one knows what is going on. The poor radiologists coming off call often look stunned and dazed on Monday mornings. After a long weekend on call, they typically have read thousands of CT images ordered by an emergency room advanced practice nurse, who likely never examined the patient for whom the studies are ordered. This certainly uses up those pesky deductibles!

During my typical private practice day, patients come in to my clinic, usually after having all their benefits extracted and exhausted, with endless bills, and they are angry. Patients just want someone to take an honest history, conduct a physical exam, and help them get better. I try to offer an explanation: “Do you recall the era of managed care?” Almost always, patients answer “yes.” I explain: “We are now in the era of ‘managed neglect.’ Instead of developing a medical differential diagnosis and treatment plan by doing a careful history, exam, and appropriate medical studies, you are seen in the context of an economic differential. That means that the cost of care is being used to narrow and determine your treatment course, while adding as many irrelevant diagnoses as it takes to maximize medical billing.”

As anyone knows who is still independent, we are price controlled, despite our practice costs increasing yearly. I pay health insurance for my employees, second in cost to payrolls, increasing often by double digits and never decreasing. To be “In Network,” I sign into shadowy and loosely defined hospital insurance networks, or their like. These opaque, unaudited entities and organizations demand “take-it-or-leave-it” agreements, leaving me with little idea or means of knowing what I am getting into. My lack of office staff and time is my enemy. Given the hospitals’ extremely effective lobbying efforts to shift reimbursements to their site of service over the last decade (to the detriment of independent physicians), I live on the thinnest of margins, constantly looking at the latest changes in my LCDs (Local Control Determination policies of Medicare) to stay afloat. Only select and obtuse ICD-10 codes are allowed for certain of the AMA’s Current Procedural Terminology (CPT) codes.

I found myself dropping out of almost all Medicare Advantage (Disadvantage) plans because of the outright lying to beneficiaries about coverage benefits and my reality of mounting unpaid clean claims. In 2019 MedPAC identified major flaws in the Medicare Advantage star-rating system, reporting to Congress that a complete overhaul would save \$6 billion. “For the past several years, the commission has pointed out the flaws of the Medicare Advantage quality bonus program in terms of its complexity, inequities in distributing

financial rewards, and opportunities for organizations to obtain unwarranted bonuses by consolidating contracts,” the report said.² To whom does one complain? On contacting our local Medicare director I was informed that they have no control over Medicare Advantage. Who does, I often wonder.

The unproven assumption that documentation of quality measures, activity improvements, forced clinical algorithms, etc., with the ever-increasing data demands, somehow equates to excellent and economical health care, is at best a public policy illusion driving the most expensive poor value and poor access health system on earth—at the expense of the most highly trained individuals on earth.

In the current model of emergency care, “the real priority is speed and money and not our patients’ care,” states Las Vegas emergency room physician Keith Corl. The *US News and World Report* article concludes that the psychological impact of burnout, early attrition, and physician suicide results from moral injury.³ Doctors are placed in a morally corrupt environment that forces them to act contrary to conscience and decency.

I see hospitals, insurance companies, physician-hospital organizations (PHOs), Accountable Care Organizations (ACOs), and government health care entities and plans as one large, loosely organized “cartel.” Designed to extract and exploit as many resources as possible from taxpayers and beneficiaries, the system leverages and pushes aside the physician, who remains the cartel’s only impediment. Years of ever-expanding budgets, and the rotating door for lobbyists and “health care” administrators have empowered those who have no moral obligation to patients. I must conclude that their lobbyists were better than our lobbyists. Or maybe as physicians, we just assumed somebody else would take care of us.

I am saddened watching employed physicians, midlevels, and nurses leveraged into longer hours with less pay, with such pay being determined by metrics such as productivity and patient satisfaction. I observe many of my patients being directed to hospital clinics receiving the same care I offer, but at about 10 times the cost, under the vertical model advocated by our current “healthcare reformers.”

Under the leadership of Henry Waxman (D-Calif.), the late Rep. Pete Stark (D-Calif.), and others, beginning in the 1990s, physicians were demonized, federalized, and portrayed as the reason for every social problem from wealth disparity to climate change. I was one day a physician, then later only referred to as a “healthcare provider” or “healthcare professional.” Now I am an implied Healthcare Comrade. Whatever I am called, I am basically irrelevant—unless someone really needs a specialty physician. Then, of course, (usually after-hours) I am very important.

I’m a “pain doctor.” Any flunked-out intern can apply to Medicare for the same position and request specialty designation (0.72 or 0.09), then start billing to receive the same payment as I do. This is the trend for midlevels as well. Credentials in Medicare’s local control determinations for pain procedures walk the tightrope of including midlevels’ program requirements, which end up being whatever one says they are.

What were once hospital medical staff bylaws have become mere suggestions, as more and more physicians, midlevels, and other dubious “providers” come into hospital employment. Many are never “board eligible,” but if they are deemed productive to the hospital, they may be

“grandfathered” in. Failing board exams three or four times in a row might be an inconvenience quickly overlooked, because, after all, one can “Google”—although a long-standing physician staff member can be expeditiously dropped for not meeting MOC requirements. Hospital quality means documentation and billing.

I see the contempt of the hospital accountants for patients who want a physician who listens, conducts a physical exam, and has the audacity to offer what appears to be best for them at one site of service, and also offers the predictability of a caring staff with continuity of care. How passé! However, though I am not in the most sophisticated area of the world, people here are not stupid, and they know when they are being exploited. They just do not know what to do about it.

What Can We Do?

I continue to be up by 4 or 5 a.m. daily to complete uploading useless federal Merit-based Incentive Payment System (MIPS) data, and I continue this exercise hours after my clinic closes, chasing useless details and changes with little or no time for my family. I am often so exhausted, especially in the last 10 years, that I often do not know how I can keep going. I have no extra time for continuing medical education programs, educational videos, or hobbies. I must concentrate on mere survival, doing everything I can do just complete charts, and not lose the essence of my patients in the process.

I ask myself why I keep going. The reason is quite simple, and it is what enables the cartel to succeed. Our dedication to medicine is what is being used against us. It happens the moment I walk into an exam room and interact with a patient and have an opportunity to help someone, to guide that person through a life crisis. This is the essence of our humanity. To quit would be to lose that opportunity for me, and to further the loss of what was once a great medical system.

A recent federal survey revealed that 32% of my county remains below the poverty level. The moment I quit, three registered nurses and four support and billing personnel would lose their jobs. I have more than 4,500 patient visits per year, mostly by elderly, cast-away individuals, with few resources and little help. What will become of them?

We can all see the poor value, poor access, and increasing

institutionalization in our medical system—and that the situation is getting worse. The cartel I have described is getting stronger. Young physicians have little knowledge of this cartel. But any physician who has experienced a sham peer review knows that cartel participants are as ruthless as drug lords. We are all placed at risk by the National Practitioner Data Bank, the Sunshine Act, Medicare fraud units, Zone Program Integrity Contractors (ZPICs), the Health Insurance Portability and Accountability Act (HIPAA), the Office of the Inspector General (OIG), medical licensure boards, and numerous other local, state, and federal agencies. All are easily accessed by the cartel. Any accusation can be and is often made, always without accountability of the accuser. If any fraud is alleged, physicians will most likely be blamed and pay the penalty, regardless of the degree of the system’s responsibility.

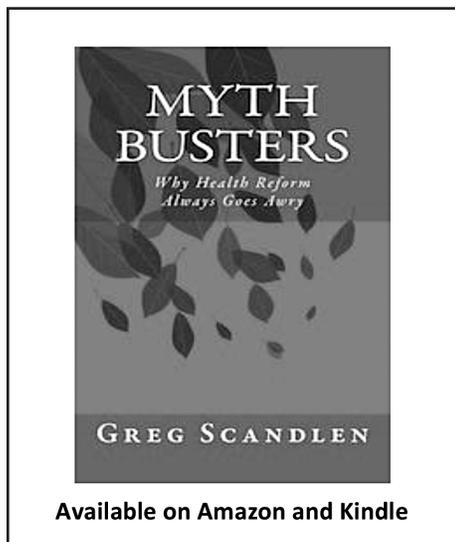
I encourage everyone to expose the truth about the burden imposed on physicians, the systematic undermining of our training and our credentials. Our place is being unraveled, debased, and used as a platform to exploit our country’s medical system—at the expense and detriment of our brothers, sisters, children, and parents—all of us.

AAPS remains as the last defense to stand up against the most incredible hijacking and exploitation of our medical system ever undertaken. Do everything you can to support this wonderful organization to defend your rightful place as a physician.

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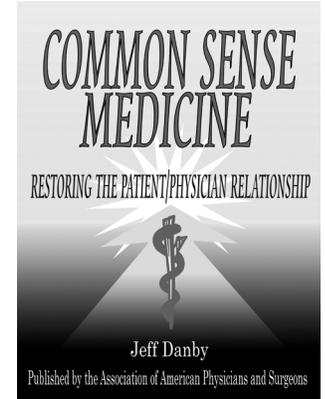
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