From the President

Quality and Advocacy: Essentials in Modern Medical Care

Paul Martin Kempen, M.D., Ph.D.

I am thankful to have had the opportunity to serve as AAPS President in spite of the many COVID-19 impositions of this past year.

As I write in July 2021, I feel compelled to recap many important developments of this year, particularly noting the impositions of media/political dominance, personal isolation, expanding private and corporate interest group entitlement, and especially the ever-increasing dominance of medical practice by multiple external forces, usurping the physician's professional prerogatives.

This was the first year that AAPS has gone without in-person membership meetings to facilitate direct exchange of ideas, collegiality, and experiences. This imposed inability to interact directly with our membership has weakened the political momentum of our core physician goals.

Isolation under the restrictive quarantine has effected numerous adverse consequences on the economy, personal lives, and medical care, although isolation has enabled me to reflect on my experiences, as well as to delve into the history of contemporary medicine. Many patients have avoided or been prevented from getting necessary medical care. The advent of vaccinations against COVID-19 infection was promised to end this quarantine. It now appears, however, that government interventions are reappearing and compromising freedoms.

One revealing new book I read during quarantine and can recommend is the story of the first three women physicians, which exposes the historically exclusionary mechanics of the medical profession, along with the inappropriate influence of society and government in excluding women from our profession.[1] Their struggle led to introducing female physicians into medical practice in the U.S. and UK in the late 19th century.

Medicine as a purely male profession was perpetuated by English-speaking medical schools and medical leaders, as well as by myths promoted by physicians, government, and society at large. This necessitated women studying medicine elsewhere, particularly in Paris. After having to go abroad for education, women faced professional exclusion from guild mechanisms under male dominance upon their return. These three women founded women's medical schools, specifically to pioneer female membership in our profession.

My personal journey through medical education in Europe and return to the U.S. as a foreign medical graduate allowed me to understand the discriminatory forces still controlling American medicine as well as the experiences of the first women. There are many parallels in the exclusionary mechanics and fallacies of the United Kingdom's General Medical Council then and now, and the American Board of Medical Specialists (ABMS) corporate monopolies in the medical profession today.

Medical Education and Competence

Prior to the Flexner Report of 1910, many private medical schools existed in the U.S., enabling significant variance in the educational quality and philosophy of the even-then-emerging level of care. This motivated limiting the numbers of physicians.

Subsequent to Flexner's report, the changes to university-based schooling, as prevalent in France and Germany, fostered the scientific method of medicine and improvements in Anglo-American standards, as well as limitation of physician numbers.[2,3] These standards and objectives are now jeopardized by political expediency to provide care to the "highest level of licensing," in which nurse practitioners (NPs), physician assistants (PAs), and others are lumped together as physician-equal "providers." Increasingly, medical decisions are outsourced to insurance companies, politicians, and especially non-physician "providers." These include practitioners of chiropractic, optometry, and various "alternate schools of medicine."

It has been estimated that more than 80 percent of medical professional time may be spent performing activities such as clerical tasks mandated by insurance or government payment requirements, activities that do not require a physician's level of training.[4] There are not enough hours in the day for a physician to attend to patients and complete the modern imposed clerical demands. "Physician extenders" were specifically trained to *assist physicians* with the clerical and physical aspects of medical care, but they are now making medical decisions at the highest levels as "providers," and even practicing independently.[5]

Systemic inclusion of these "physician extenders," along with computerization demanded by third-party payers, has increased total costs and made private practice financially precarious.

Not all "doctors" degrees are equivalent. As an M.D. and Ph.D., I can state that these degrees are not the same thing. They were very separately attained. "Doctorate" designations lead to confusion for patients, who become unaware that they are being seen by less adequately trained nurses and PAs with doctorate degrees, who are often educated extensively by online "virtual" schooling, or unsupervised "on the job" training. Recently, physician assistants have unilaterally (and possibly illegally) changed their professional title to that of "physician associate," to imply equality and further confuse patients as to the educational attainments of their "providers."[6]

Even more compromising to quality patient care is the way insurance corporations limit care by requiring pre-authorizations, specific referrals, corporate formulary restrictions, and specific locations of care delivery by "in-network providers," and "preferred provider care" specifically by non-physicians—naturally, to limit corporate costs.

"Coverage" Limits Care

Referral for specialist care in many regional centers has led to assertions of "surprise billing," which in reality is best described as "surprise nonpayment for services by insurance companies," especially when patients must travel out of state or submit to arbitrary limiting boundaries of the insurance company's

regional services for needed care. Everyone traveling outside the U.S. recognizes the need to carry "travel insurance," as national insurance corporations and even Medicare specifically state that their coverage extends only to "providers accepting payments as dictated by Medicare/Medicaid" and is generally unavailable outside this country.

Regionalization of national companies to specific states and "providers" is a limitation of service poorly understood by the average American, but corporations here use this scheme to impose payment limits on all physician care.[7]

In the 40-plus years of my professional career I have seen medicine progress from personal and long-term physician-patient relationships and direct payments (with patient's recouping fees directly from their insurance agents under that coverage), to the current situation in which insurance price-fixing is widespread, and patients are steered by their insurance programs to receive care as dictated by arbitrary corporate limitations. Patients are also repeatedly required to change providers from long-term physicians because insurance coverage and or employment has changed, forcing them to use alternate "in-network" rosters of "providers," typically at lower cost to the corporate entity.

Greater use of non-physician "providers" also serves corporate goals by imposing "care guidelines" on patients. These often obviate clinical judgment that would fit the treatment to the individual patient, and the COVID-19 crisis has only made this more evident. Most astounding is that while medicine's increasing complexity has led to large increases in the time it takes to train physicians and keep them current, we now see "providers" trained in nursing schools, and then after one to two years of "advanced nursing training," they are given license to *independently practice medicine* (not nursing) without oversight by state *medical* boards.

There is no numeric shortage of physicians in the U.S., compared with other countries. There is however, an overwhelming imposition of documentation by government and corporate America, including the certification industry, draining physician work hours. The U.S. has more physicians per 100,000 people than other advanced medical systems, such as in Germany or the UK, where other "providers" and mountains of electronic billing "paperwork" are not commonplace.[8]

Advocacy in Medical Care

Decimation of the prolonged and personal patient-physician relationship over these past decades, especially during these months of COVID-19 quarantine, has led to a major degradation in quality of care. Where a primary-care physician (PCP) was once touted as the integral "future of medicine gatekeeper" during the era of the Health Maintenance Organizations (HMO), conceived in the 1980s to improve quality and minimize costs, medicine has been transformed to a system of "providers" and "health care networks" with physicians in the distant background, who may never actually meet a patient during life-threatening hospitalizations.

Increasingly, care is limited to single-issue treatments in urgent-care facilities, eliminating comprehensive holistic applications. Advocacy is the essential component of quality care, especially when patients are compromised by disease and pharmacological interventions. The outcome of care is exceptionally dependent upon the quality and engagement of the personnel caring for a patient. COVID-19 forced patients into hospitals and kept family advocates distant, typically providing little important information or authority for making decisions.

Over-extended shift workers frantically lamented the many patients "dying alone" on respirators, while the general population was encouraged to remain distant from others in our "national quarantine." Fear was actively injected into the national consciousness, leading to avoidance of hospitals and physician offices. Important regularly accessed medical care, treatment, investigation, and information was not sought out or reliably provided to a large proportion of the population, who were advised to stay home.

While deaths were easily quantified as "COVID-19 deaths," many persons were compromised by avoidance of health care, necessary treatments, and check-ups in facilities. Many more died because hospitals had inadequate advocacy for their welfare, while family members were barred from advocating, and were not even allowed to enter the room. When a patient is isolated in a hospital from familial advocates, the importance of an interested, personally involved, and competent physician cannot be overstressed or underestimated.

I had heart surgery in December 2020. I sought out the regional center of excellence, yet still faced complications. As a physician, I was able to recognize and insist on appropriate interventions, in spite of resistance from nursing personnel adhering to "institutional protocols." I was able to enlist on a personal and professional level a hospitalist physician colleague to become my advocate and ensure that I received the care we recognized as appropriate. Even a physician patient can have difficulty asserting rights and insuring optimal care.

Nursing personnel during COVID-19 were willing to help but were also restricted by the many institutional "guidelines" and the December holiday season's limited physician availability. I can clearly state that advocacy is an integral component of quality care even in premier institutions. All patients should have the ability to have a familiar and concerned physician of choice leading their care—especially those who are not physicians themselves. AAPS advocates strongly for direct patient care (DPC) models, recognizing the importance of personal physician involvement and direction in assuring both quality and cost containment in every patient's care.

Media and Truth in Medicine

The most concerning facets of the past COVID-19 year included the unknown nature of the disease effects early on, and the multiple wrong directives and facts provided by governments and their experts, including economic shutdowns, media fearmongering of the general population, and the promise that vaccination could definitively eliminate the disease.

While the early erroneous recommendations may be understandable due to lack of information at that time, we have now clear evidence that COVID-19 infection is clearly possible after completed immunizations. Political dogma has been imposed as medical dogma. COVID-19 vaccination is still generally recommended for the elderly, the immunocompromised, and those with underlying conditions, but there is hesitancy about vaccination in children, who have very low mortality risk, as do the millions of recovered COVID-19 patients.

The vaccine remains "investigational" without FDA approval, specifically including any "booster shots," for which

the indication has yet to be validated. Serious side effects have been identified, though described as "rare," and include paralysis and myocarditis, which may not resolve and may cause death. Documented breakthrough infections, international travel with world reservoirs of disease, the uncontrolled U.S. Southern border, and the rapid genetic mutation of this coronavirus all make suspect the belief that vaccination can end the disease through "herd immunity."[9] There might also be transmission from non-human animals.

Unlike smallpox, which confers lifelong immunity on survivors, this respiratory disease will likely be more like influenza, recurring seasonally with multiple strains. Multiple variants have already been identified, making immunological shifts in protective antigens probable. If already proposed COVID-19 "booster" shots become commonplace, allergic phenomena are likely to further complicate the spectrum of side effects.

Yearly government-mandated COVID-19 vaccinations appear to be likely, imposing as-yet-unknown risks and costs, for unknown benefits. When these vaccines become FDA-approved, we may also see widespread legislated and employment mandates forcing universal immunizations on all age groups, much as for school attendance in children. Some employers, especially hospitals, are already firing or threatening to fire non-vaccinated workers.[10]

We listened to daily news reports of increasing death rates, which ignored the vastly larger numbers of COVID-19 survivors. As of Jul 19, 2021, 30 million people had recovered from COVID-19 in the U.S., and the 625,000 U.S. deaths attributed to COVID-19 occurred primarily in the elderly population.[11] We have been inundated for decades with the lament that overpopulation is leading to deadly climate changes, and COVID-19 has been viewed as nature's attempt to correct this—assuming that the virus did not originate in a laboratory.

Many deaths may have been incorrectly ascribed to COVID-19. At first, no verification tests were available, and increased reimbursements for hospital care incentivized COVID-19 diagnosis.

The many wrong or inconsistent COVID-19 answers provided by the government and media over the past months have undermined trust in the reliability of these sources. Political direction now seems toward reaching arbitrary vaccination goals as political hubris. It appears that only the government can have a monopoly on "facts." Such "facts" require us to believe that China has not had a COVID-19 death since Apr 23, 2020, based on available Chinese-provided data.[12] Is American government information reliable? With 30 million Americans known by public data to have recovered from COVID-19 to date, until a "booster" immunization is documented as necessary or effective it is unreasonable for any legislation to mandate vaccination for anyone known to have recovered from this disease.

Everyone in the U.S. older than 11 who wants a COVID-19 vaccination can now receive it. The choice is personal and should be a constitutionally protected freedom. Americans continue to abuse abortion, over-eat, and use tobacco and alcohol, which together kill more people each year than COVID-19, yet these choices are permitted. The choice, however, must be fully informed.

Given the low COVID-19 risk in younger people, who may already have had benign COVID-19 infection resulting in immunity superior to that of vaccines, the unknowns of vaccine side effects after infection argue against universal vaccination. Vaccination of anyone after having COVID-19 is inappropriate, but this is not recognized in the current universal vaccination objective of the Biden Administration. The inaccuracy in previous governmental pronouncements shows the danger of any such universal plan.

Conclusion

There are always many reasons for physicians to unite for professional, personal, and patient protections. This is especially important now that multiple forces, immune from oversight, are usurping physician leadership

AAPS is the one national physician membership organization actively supporting medical care that places the patient first, based on the traditional principles of America's founding and the Constitutional protection of individual rights. Active AAPS membership and participation are needed more than ever now to protect our patients and our profession. We will refuse to be overwhelmed by media, corporate, and government fearmongering and intimidation.

Paul Martin Kempen, M.D., Ph.D., is a practicing anesthesiologist and serves as president of AAPS. Contact: kmpnpm@yahoo.com.

REFERENCES

1. Campbell O. *Women in White Coats*. Fribourg, Switzerland, and New York, N.Y.: Harlequin Books; 2021.
2. Flexner A. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*. Bulletin No. 4. New York, N.Y.: Merrymount Press; 1910.
3. Bonner TN. *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States*, 1750-1945. Oxford University Press; 1996.
4. Masters PA. Practice at the top of your license: What does that really mean? KevinMD.com; Feb 5, 2019. Available at: https://www.kevinmd.com/blog/2019/02/practice-at-the-top-of-your-license-what-does-that-really-mean.html. Accessed Jul 21, 2021.
5. Bean M. PAs seek new title: 'physician associate.' Becker's Healthcare; May 28, 2021. Available at: https://www.beckershospitalreview.com/quality/pas-seek-new-title-physician-associate.html. Accessed Jul 21, 2021.
6. O'Reilly KB. PA rebrand as "physician associates" will deepen patient confusion. AMA; Jun 16, 2021. Available at: https://www.ama-assn.org/practice-management/scope-practice/pa-rebrand-physician-associates-will-deepen-patient-confusion. Accessed Jul 21, 2021.
7. Association of American Physicians and Surgeons. The "No Surprises Act" is a surprise attack on patient choice and the Constitution. Action Alert; Dec 12, 2020. Available at: https://aapsonline.org/the-no-surprises-act-is-a-surprise-attack-on-patient-choice-and-the-constitution/. Accessed Jul 21, 2021.
8. Wikipedia. List of countries and dependencies by number of physicians. Available at: https://en.wikipedia.org/wiki/List_of_countries_and_dependencies_by_number_of_physicians. Accessed Jul 21, 2021.
9. CDC COVID-19 Vaccine Breakthrough Case Investigations Team. COVID-19 Vaccine Breakthrough Infections Reported to CDC—United States, January 1–April 30, 2021. *Morbidity and Mortality Weekly* 2021;70(21);792–793. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm. Accessed Jul 21, 2021.
10. Stieber Z. New Jersey hospital system fires employees who didn't get COVID-19 vaccine. *Epoch Times*, Jul 22, 2021. Available at: https://www.theepochtimes.com/new-jersey-hospital-system-fires-employees-who-refused-to-get-a-COVID-19-vaccine_3913475.html. Accessed Jul 21, 2021.
11. Worldometers. United States. Available at: https://www.worldometers.info/coronavirus/country/us/. Accessed Jul 21, 2021.
12. Worldometers. China. Available at: https://www.worldometers.info/coronavirus/country/china/. Accessed Jul 21, 2021.