

# Editor's Notes

## On Finding Ourselves at War

By *Kenneth Y. Pauker, M.D., Guest Editor*

**W**e are at war, and we had better understand that, and act like it. Although we are reluctant soldiers in what has become an expanding and intensified struggle for the safety of our patients and the viability of our profession, fight we must. We cannot simply be conscientious objectors for the reason that we are ethically obliged to secure ground that was made sacred by—and inherited from—our forebears.



Arrayed against us are forces that seek to redefine who we are and what we do. There are those who, to advance their own economic and political agendas, fully intend to divide our House of Medicine and enslave and muzzle us, to break our spirits, to further alienate us from the patients whose welfare has always been at the heart of our medical journey. There are others, so-called “do-gooders” and health care planners, who mean well enough, but who, with their imperfect understanding of the nitty-gritty of the actual practice of medicine, would restrict us, redirect us away from the essentials of our professionalism, create hurdles and diversions that distract us and consume our time and energies, and to boot, visit upon us a plague of unintended consequences. And then there are the usurpers—circling, lurking, and pouncing on opportunities as they present themselves, trying to carve out a little something more for themselves.

So who are we? We are the descendents of Hippocrates, practitioners of an ancient method of discourse and learning, perpetual learners—an inquisitive, reasoning, obsessive, and compulsive lot. We are delayed gratifiers, sublimators, idealists laboring to attain satisfaction in the pursuit of what often seems just beyond our reach. We sleep too little, drink coffee freely, work too much, and spend less time with our families than they want and we should. We are protectors of our patients and our surgeons alike, but we are no one's tools, despite how planners, administrators, industrialists, and insurers see us. How we think and what we do and how we interact with others as consultant specialists is entirely integral to the profession of medicine, and is as far removed from nursing as surgery is from nurse assisting, or lawyers are from paralegals. Respectfully, and grateful for the expertise and professionalism of nurses everywhere, we are nobody's nurses. For that matter, nurses are also nobody's doctors, whether or not they sport a shiny new doctorate in nursing, which they earned from an on-line correspondence course.

## Editor's Notes (cont'd)

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Our mentors taught us to approach clinical problems with a logically conceived and well-honed pattern of behavior, to use a repetitive pattern of a sequential series of small steps to proceed down a path, whether straight or winding, in pursuit of patient safety, comfort, efficiency, and optimal outcomes. We are uncomfortable with protocols, although we can and do author them and follow them when appropriate. We fully understand that, as physicians, we must individualize care, certainly within a certain spectrum of evidence and induction, always cognizant of the all-too-frequent lack of true scientific data to apply to a specific circumstance. We anesthesiologists balance risk and benefit as a profession, and know when to hold 'em and when to fold 'em.

So who, then, is the enemy with whom our relations have devolved to the point of war? First and foremost, powerful and essentially unchecked as we have seen merger after merger and the amassing of monopsony power, are the **health insurers**. They have over time ceased being insurers in the common vernacular, but now see themselves as guarantors, regulators, protocol makers, evaluators, and profit makers for executives and investors. They are the poster boys for capitalism gone amuck. What did the public gain from health insurers giving up their nonprofit origins? We need to revisit this development and consider legislating a return to the earlier time of health insurance non-profits. Even the government now is making noise about reigning them in, but the insurance lobby is so big and so smart and so powerful that it is much more likely that they will find a way to turn current proposals to their advantage, to stand bad publicity on its head, and to snatch victory and massively increased profits from the jaws of defeat. A subset here is the HMO, and by this I mean the IPAs and "HMOs without walls." Vertically integrated HMOs like Kaiser are an entity of another color, and my notion is to require all HMOs to be "in-house" and all physicians to work in one system or the other, but not both, or alternatively to require those that are not vertically integrated to have "loss ratios" comparable to those that are. One major post in CSA's "war ministry" will be that of Chair of the CSA's LPAD Subcommittee on Insurance Abuses. Read more about this in my September LPAD Report (on the CSA Web Site at [http://www.csahq.org/pdf/prof/402-1\\_LPADChair.pdf](http://www.csahq.org/pdf/prof/402-1_LPADChair.pdf) ).

Next on my hit parade of "enemies of the state" of grace are **plaintiff attorneys** and our (more appropriately, "their") system of adjudicating claims of medical malpractice. We have been told over and over that what we have in California, MICRA, is the best system in our nation. To me that is not nearly good enough. We still have essentially a lottery, lawyers sharking around continually in search of a really big hit. Pretty much none of this is about the "Truth of the Matter," but rather it is all about money, pure and simple, and sometimes a

## Editor's Notes (cont'd)

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whole lot of money. I visited this issue in microcosm in a previous piece, "Medical Liability Reform and the Case of the Dislodged Tooth" (see the Board report online at [http://www.csahq.org/pdf/bulletin/issue\\_7/pauker044.pdf](http://www.csahq.org/pdf/bulletin/issue_7/pauker044.pdf)). Huge amounts of resources are wasted in defense of frivolous claims, and fear of being sued drives all of us continually to generate the expenses of practicing defensive medicine. How about considering the creation of special health courts of professional jurors who become educated about how medicine works and what is malpractice and what is not, what should be compensated and what must not? How about the pre-screening of cases by a panel of experts? How about three strikes by a plaintiff attorney and you're out, just as they do to physicians in Florida? How about the abolition of contingency fees, as is the case in most other civilized western countries? How unlikely to achieve any meaningful tort reform through any legislative body, chocked full, as they all are, of attorneys who are members or staff who write the laws, lobbied by attorneys who know the legislators personally after having themselves served with those legislators, and then with attorneys turned judges to adjudicate any conflicts? How about meaningful restrictions on past legislators serving as lobbyists—restrictions with real teeth and enforcement? In California, such reforms will have to be done through the initiative process and will be very expensive, perhaps costing \$2 million to qualify a measure for the ballot and then another \$3 million to run a campaign to get it passed.

The government, primarily the **executive branch**, repeatedly demonstrates its lack of understanding of how things work now and what will work to make things better, and moreover what will be destructive of quality patient care and safety. Just consider President Obama's pronouncements and positions and Governor Schwarzenegger's bogus opt-out. Regulators such as the **Joint Commission**; California's **Department of Managed Health Care**, **Department of Health Care Services**, and **Department of Public Health**; and the federal **Centers for Medicare and Medicaid Services** and **Federal Trade Commission** most likely mean well, but too often are misguided and unnecessarily intrusive, and routinely are clueless about the unintended consequences of their actions. Courts, particularly the **California Supreme Court** and the **U.S. 9th Circuit Court of Appeals**, legislate from the bench. Legislators, however, do respond to our efforts as their constituents at explaining and exhorting, and do sometimes change their minds, as we now are seeing with the public option debates raging across America.

The **AANA**, for decades, has been a thorn in the side of organized anesthesiology. The anesthesia care team mode of practice wherein nurse anesthetists and/or anesthesiologist assistants work within a defined team model, sharing fundamental concerns about quality of care and patient safety, is well

## Editor's Notes (cont'd)

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recognized as safe and effective. Nurse anesthetists always have been welcome to participate in this mode of practice. In contrast, the “independent” practice of nurse anesthetists constitutes a significant departure from a viable culture of safety. The AANA’s well-funded campaigns for “independent” practice appear to me to have been largely self-serving, inaccurate, and misleading. Within our current national debate about health care reform, organized anesthesiology must be willing to stand tall for the Truth of the Matter, such that anesthesiologists set the standards and serve as the ultimate advocates for the anesthesia care provided for the citizens of our country.

And last, but certainly not least, we are **at war with ourselves**, our alter egos in other specialties who all too often want what they need for themselves, no matter the cost to others in the House of Medicine. Our state and national medical professional societies are fractionated and often nonfunctional. We contribute to organizations within medicine that lobby against the positions of one another. As Pogo wisely observed, “We have met the enemy, and it is us.” We must discuss and find a better way to advance our positions, form new alliances across specialty lines, and determine whether old methods are no longer effective for us in promoting quality and safety in our own specialty.

I call upon all CSA members to step up to participate in these many battlefronts of our larger war, to labor and to sacrifice for upholding our sacred trust with our patients, to don our martial accoutrements, and to assume warlike attitudes and determination.

*A typical vice of American politics is the avoidance of saying anything real on real issues.*

*Behind the ostensible government sits enthroned an invisible government owing no allegiance and acknowledging no responsibility to the people.*

— Teddy Roosevelt, Colonel in First U.S. Volunteer Cavalry Regiment  
(so-called “Rough Riders”), 26th President of the United States

*In addition to Dr. Pauker’s active participation in CSA activities ([http://www.csahq.org/pdf/board/Pauker\\_rev.pdf](http://www.csahq.org/pdf/board/Pauker_rev.pdf)), he is a member of the ASA Committee on Performance and Outcomes Measurement and the ASA Committee on Anesthesiologist Assistant Education and Practice.*

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and not CSA policy.*

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