

# THE BULLETIN

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To promote the science and art of medicine, the care and well being of patients, the protection of the public health, and the interests of the medical profession.

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Original tree art by Samuel P. Burre, M.D. (1957) and  
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# Interview With Your New President

**HAL GROTKE, M.D.**



**What made you become a doctor?**  
My mother tells me I was 4 years old when I first announced that I was going to be a doctor. My little brother was in hospital. He had Wilm's tumor. I remember being jealous of all the attention he got. I don't remember a time that I was not going to be a doctor.

That said, I did not take a very direct route to my present career. For various reasons that are not so important now I finished high school with a 1.9 GPA. I found out I was graduating when I showed up at graduation rehearsal and saw my name on the list. After that I knew I was supposed to go to college so I enrolled at a community college. I didn't know how to be a student and dropped out after a semester of a couple C's and a couple of Incompletes. I dropped out of 2 more colleges before I accepted that I was an academic failure and went into the work force. After a year or so of that my roommate from whom I subleased moved and I couldn't find an apartment I could afford. After living on the street for a few months while continuing to work full time I enlisted in the military. I trained to be a surgical scrub tech and got to meet a number of doctors. By listening and watching I learned that there is a skill to being a student and a method to getting into medical school. I got out of the Navy, earned my bachelor's degree in 3 years and moved on from there.

Even with my new found knowledge of the process of education I could not have accomplished what I have without the support, financial but more importantly emotional, of my wife Alice. To this day I cannot imagine how a young, single, inexperienced person could navigate the gauntlet of

higher education.

**How did you end up in this field of medicine?**

My last duty station was the Naval Hospital Camp Pendleton in San Diego County. There is a family medicine residency there. Before that I don't think I had even heard of family medicine. Working in the general surgery clinic I got to know a number of the residents and medical students rotating from College of Osteopathic Medicine of the Pacific (now Western University). I learned about what family doctors learned and a little bit about what family doctors do.

While I was still in high school I joined the local volunteer fire department and rescue squad as an ambulance attendant. Unlike most of my colleagues I always preferred ambulance calls of more of a medical as opposed to trauma nature. In the three years I was stationed on Navy ships one of my roles was as leading petty officer for sick call. I enjoyed the great variety of care I provided to my shipmates. Like most surgical techs I was known for my skills in minor surgical procedures and wound repair but I also greatly enjoyed caring for those who were ill. Family medicine just seemed like a good fit.

**How did you end up in medical politics?**

I grew up in Maryland just outside Washington, DC. My father was a lawyer with Department of Health, Education and Welfare and when I was 5 years old he presented oral arguments to the Supreme Court in favor of busing for mandatory school desegregation. Our neighbors spray painted

racist epithets on our house. I started reading the front page of the Washington Post at about age 12. At 15 I was "detained" outside the South African embassy for protesting apartheid. (We were all later released when the police accepted the permit as legitimate.) I suppose I have always been involved in civil rights causes. Even when I was stationed on a nuclear propelled aircraft carrier outfitted with nuclear bombs and missiles I was supporting the Greenpeace Nuclear Free Seas program.

A currently active and, I think, critically important civil rights cause is "health care reform." Inasmuch as the Declaration of Independence specifically lists Life as an inalienable right and inasmuch as access to affordable medical care prolongs life and improves quality of life I believe that such access to care is a fundamental human right. I further believe that society, collectively, has an obligation to afford such access to all the people in every way possible.

We physicians are greatly respected by the people in general and by the public servants specifically. We are well educated and we, along with our dental colleagues, are the only people with doctoral level education that most of the population ever meet first hand. We also have intimate knowledge of issues of access to care at ground level. Our opinions are respected and seriously considered even when we are a minority voice. When we speak collectively we have significant power. Right now I believe that the collective physicians' voice is speaking the wrong words and sending the wrong messages. I want to fix that from within.

**What brought you to Humboldt County?**

Alice grew up in the San Fernando Valley in Los Angeles. We wanted to live a little closer to the ocean and moved to Ventura when I finished residency. We wanted to buy a house and live a life like we had known our parents to live when we were kids. We found that we couldn't afford to buy a decent condo in a decent part of town and decided to try to save for a down payment. A couple years later we couldn't afford to buy a crappy condo in the ghetto and started thinking about moving. About that time I got a postcard in the mail from a headhunter that said "California coastal community with affordable housing needs a family doctor." I emailed the guy and told him "I don't believe you but tell me about it." I started researching the area and found it to be inviting in a number of ways. While this was going on Kaiser opened their first clinic in Ventura. In the office where I was employed about 30% of the patients had Kaiser insurance contracted through the IPA. When that chunk of the business went away overnight I got laid off. It was time to move.

**What do you see as the biggest challenge this year?**

From the perspective of organized medicine my biggest challenge personally is accepting that we are not going to get meaningful health-care reform. On a much larger scale we have the problem bringing the collective voice of physicians around to support of the greater good. Perhaps I should not set such lofty goals.

**Do you have any specific plans for HDNCMS during your presidency?**

For years one of our members has annually presented an excellent resolution in favor of Single Payer Health-care to the House of Delegates. I want us to borrow that resolution from her and present it as a gift to HOD from HDNMS collectively.

**Besides the monthly President's column ..... what do you see as issues during your term?**

I think we need to clarify for ourselves our relationship to CMA. Several months ago, after our members overwhelmingly indicated support for Single Payer Health-care, I proposed that we should publicly support SB 810. I was told that as a subsidiary of CMA we could not take a position different than that of CMA. At HOD this year the CMA chose to support the current house bill for health care reform. The day after the close of HOD the Los Angeles County Medical Association made a press release stating that CMA had erred in support of that bill. I do not think that CMA should be fractured. I do think that dissent is a high form of patriotism. If the ultraconservative doctors in liberal LA County can dissent I think the liberal doctors in liberal Humboldt and Del Norte can dissent.

**What do you see as the biggest problems facing physicians?**

- unique problems?

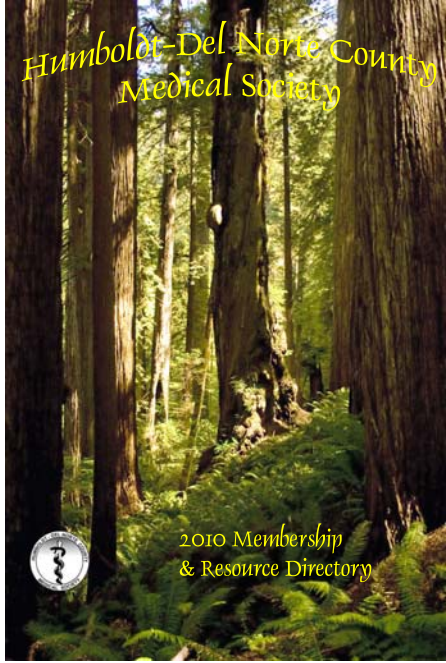
It is becoming progressively more difficult to balance the moral and ethical obligations to care for people with the practical need to earn a living. Individually most of us seem to be doing reasonably well financially. However we are all aware that the companies for which we work (or which we own) have fiscal health which is tenuous. The sense of need for self preservation is consuming. So far I am not aware of any patients who have been harmed as a result of this difficult balance but it is easy to imagine that such harm is possible.

**What are your interests outside medicine?**

My favorite hobby is cooking. I have been told I'm pretty good at it. A couple of months ago Penny and I tried to figure out a way for me to cater the annual meeting. We couldn't think of a place with an appropriate kitchen and an appropriate meeting room. I'll keep working on that. I also enjoy bicycling and hiking and traveling. Other stuff too. §

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# Devil's Glossary of Non-clinical Terms: v 2.0

STEPHEN KAMELGARN, M.D.



**T**his was a guide originally published by the CMA back in 1993 (during the Clinton Health Care Reform debacle) as an aid for medical journalists covering health care in California. Version 1.0 of the Devil's Glossary was published way back in 1994. I felt that it was time to revisit the issue.

The guide was published using the usual bureaucratic jargon, so (in the finest tradition of Ambrose Bierce) I have liberally provided a translation.

**Accreditation:** A process by which a number of licensed bureaucrats (medical and non-medical) pass judgement on the adequacy of one's hospital institution. This gives them a feeling of self-importance, and makes the accredited institution feel loved and wanted. See *JCAHO*

**Advance Directives:** More paperwork to remain unread in a patients' chart concerning preferences about life-sustaining procedures. Unfortunately, these are almost never available when the patient is comatose in an emergency department, thereby making their existence moot.

**All-payer system:** A health care pricing or reimbursement system in which all payers, including insurers and government programs, must participate and pay an equal percentage of nothing for physician, hospital and other provider services. In the old days this was referred to as *Price Gouging*, but we live in enlightened times now, and this could never happen in America.

**Ambulatory care:** Care delivered only to people who can walk and pay at the same time.

**American Medical Association (AMA):** A national association of fossilized old men

still living out in the medical practice climate of the 1950's and 60's, fighting yet another rear-guard action against Health Care Reform. They claim to be the voice of organized medicine, but since fewer than 20% of practicing physicians belong, they are living in a fantasy world. Today, there are high powered psychotropic medications to dissolve their delusions of relevance.

**Attending physician:** The physician on the medical staff who is usually the first name to appear in any malpractice litigation.

**Bioethics:** The study of the ethical implications of bio-medical technology and practice. Topics include (but are not limited to): Can a surgeon write-off the cost of leaving a hemostat inside a patient's incision; are lawyers or insurance underwriters deserving of medical care; is it ethical to fire bomb the office of the insurer who denies pre-approval for a simple test or procedure that may save a patient's life.

**Bio-medical research:** One of many ways to tap into government coffers to pursue one's pet projects. This is usually affiliated with major universities where the president or department chair needs new living room furniture.

**Budget predictability:** The fantasy that one can plan in advance for expenditures over a stated time period. In health care, the relationship between predictability and actual expenditures is tangential, at best, thereby leading to both a *credibility gap* and health care oversight by CPA's, bookkeepers, and other bean counters whose knowledge of medicine is gleaned from past issues of *Reader's Digest* and *The National Enquirer*.

**Capitation:** A method of payment for health services that is the darling of Kaiser-Permanente, insurance companies and other HMO health policy wonks. A provider is paid a fixed, less than subsistence fee for each person served over a period of time without regard to how much care that person actually requires. This method of reimbursement has the not-so-subtle incentive to under utilize services, thereby placing the health care provider at higher risk, since capitation has not been accompanied by *legal tort reform*.

**Cherry picking:** Yet another clever ploy by insurance companies to increase their profits. Here, they only accept healthy people for coverage. They then have the option to cancel that person's policy as soon as he/she gets sick, and really needs the insurance. This is all quite legal, and exemplifies market economics at work.

**Churning:** A practice whereby insurance brokers convince groups (or individuals) to switch insurers in search of the holy grail of lower rates; sometimes as often as every year. Since there is usually a 90 day clause before the new policy takes effect, and pre-existing conditions are excluded from coverage, everybody but the insured individual comes out ahead. The brokers get increased fees, and the insurance companies get premiums from people they don't have to pay for. Another pithy example of market economics.

**Clinical autonomy:** An outmoded concept where the physician's medical judgments were based solely upon his/her training, experience and specialty. In today's enlightened, interdependent world, this concept has gone the way of the horse and

buggy, and we now know that basing our clinical care on the pre-approval of a high school drop-out who can't spell MRI, is a much more democratic and egalitarian way of caring for patients; oops, I mean clients.

**Collective bargaining:** A comprehensive term that encompasses the negotiating process between workers and management on wages, hours, and other conditions of employment. However, when applied to medical practitioners the process is referred to as *Price Fixing*, and any group of physicians that band together for the purpose of negotiating reimbursement rates from an insurer stand a good chance of facing *Anti-trust violations* and an appearance before a government grand jury. The take home message is if one wishes to negotiate with another agency, get out of medicine and get in the unemployment lines.

**Community rating:** Anathema to the insurance industry. A way to set health insurance premiums based upon the expected or actual health care experience of the population of a geographic area. Horror of horrors, premiums are not individually adjusted for age, sex, risk factors, or use of health care services. This lowers everyone's premiums, the insurance companies go broke and all those beautiful glass skyscrapers once owned by the insurance companies are sold to the Chinese since they own everything anyway.

**Congress:** That assemblage of 535 guardians of the public good that are supposed to watch out for our interests. This is accomplished by allowing all Health Care legislation to be written by lobbyists for the insurance and pharmaceutical industries, and environmental legislation to be written by lobbyists for the oil and coal industries. They feel that the people they represent are children that need to be led by their betters, i.e. wealthy pressure groups who can finance their re-election campaigns.

**Controlled substances:** Drugs or drug

products that can get one high, and offer addictive potential. In yet another feeble attempt for the government to attempt to curb the supply of drugs of abuse from making it to the streets, the Drug Enforcement Administration (DEA) is charged with regulating these substances. This is accomplished by paying the DEA \$210 every other year for the privilege of receiving a green piece of paper that states one may prescribe these substances. And for 7¢ a prescription we can prescribe the truly dangerous drugs to our patients who are in serious pain. The net result of all these regulations has about as much effect in stemming illicit drug use in this country as trying to stop the incoming tide with a colander.

**Cost containment:** An assemblage of strategies to help keep health care costs down. This usually results in decreased reimbursements to the physicians who only use about 15% of the total health care cost, whereas administrative costs consume 25-30% of health care dollars. As more and more strategies are enacted to keep cost down, the number of oversight bureaucrats will increase to make sure that physician and provider reimbursements stay down in direct proportion to the concomitant escalation of administrative costs. Go figure.

**Cost shifting:** A financial management strategy where one robs Peter to pay for Paul's health care. A direct application of the Marxist dictum, "From each according to his abilities to each according to his needs."

**Diagnostic Related Group (DRG):** a patient classification system that pigeonholes patients into some accountant's model of disease. DRG's provide the framework to place yet another group of people into the hospital environment to obfuscate and find ways to obtain an adequate reimbursement from the federal government; i.e. heart attack complicated by pneumonia gets a higher reimbursement than pneumonia com-

licated by heart attack. It's not what you say, but the way that you say it.

**Economic credentialing:** The use of economic criteria, i.e. how much money does the doctor make for the hospital, to determine a physician's qualifications for medical staff privileges. This contrasts to *clinical autonomy* (see above).

**Electronic Medical Records (EMR or EHR):** That mirage-like panacea of all "health-care experts and bureaucrats" whereby a patient's medical file is stored out in cyberspace. This is supposed to lead to less redundant redundancy, greater accessibility and better patient outcomes. And, if we add the eye of newt and wing of bat, we can let the computers do all the work, including the dispensing of meds. For the non-reimbursable price of more than \$250,000 the physician has the joy of being left in the dark when his computer system crashes or is hacked by any 10<sup>th</sup> grade delinquent.

**Emergency room (ER):** A unit that provides immediate evaluation and treatment for patients. This exempts them from the need of making an appointment with their own physician who can handle the same problem for less than half the cost.

**Expenditure cap:** A fixed limit on total spending for a fiscal or calendar year. Once that limit has been reached, there will be no further funding until the next year. Take home message: get sick at the beginning of the year.

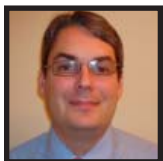
**Fee-for-service:** The darling of the AMA and most right thinking physicians whereby a hospital or physician bills for each encounter, treatment or service rendered. This contrasts to *capitation* (see above). This has the not-so-subtle incentive to over utilize services and for physicians to go into high paying, procedure driven subspecialties. Why see a patient once, when you can see them

**"Terms" Continued on page 11**

# Medical Student Update



Hello! My name is **Michelle Mora- Wiley**, and I am a fourth year medical student at Touro University in Vallejo. I am originally from Colorado, where I attended Colorado State University and majored in chemistry and mathematics. I was a wildland firefighter most of my college career. I decided I wanted to attend osteopathic medical school after a traumatic injury that led to a very positive experience with a DO. When I'm not studying, I enjoy hanging out with my husband Andrew (a fellow medical student), running, hiking, rock climbing, swimming and of course Halo video games! We have two cats, a brother and sister, named Atlas and Axis.



Hi, my name is **Andrew Wiley** and I am a fourth year medical student at Touro University California College of Osteopathic Medicine. My primary interest is Internal Medicine and I am currently in the process of interviewing for residency positions in this field. I also have an ongoing interest in cancer research which dates back to my previous life before medical school. I conducted gene expression studies of cancer cell lines while working for a biotechnology company and molecular epidemiology studies involving breast and ovarian cancer at Yale University where I completed a Master's in Public Health degree. I was recently married in September to a lovely young woman who is also a fourth year medical student. We look forward to rotating in Eureka and thank you for the opportunity you have given and continue to give Touro University students.

for taking care of Medicare patients. HCFA provides a last refuge of employment for unemployed Swiss miniature makers; they design all the forms that will take the smallest "X," that if not correctly placed in the box will mean forfeiture of reimbursement.

**Health Care Reform:** Congress' annual kowtowing to the Insurance and Pharmaceutical Industries. (How many lobbyists can dance on the head of a senator?), and the public be damned. It's the modern version of "Let them eat cake."

**Health care sector:** The only part of the US economy that has shown any growth at all in the last 5 years.

**Health Maintenance Organization (HMO):** An organized system for providing capitated care (see above). However, with the help of smoke and mirrors, subscribers who think they're covered will find themselves bankrupt and out in the cold while the HMO directors enlarge their bloated accounts in the Caymans.

## "Terms" Continued from page 5

3 or 4 times, and get paid for each visit?

**Food and Drug Administration (FDA):** a federal agency who looks out for our welfare by insuring that foods, drugs and biological products are safe and effective. 30 years ago they saved the American public from the dangers of Thalidomide, and are still touting that victory today as a reason for not utilizing European experimental data and licensing new drugs sooner.

**H1N1 (Swine Flu):** This year's "epidemic de jour." When the Public tires of reality TV and shows like *Fear Factor* they can rely on the health reporters and epidemiolo-

gists around the world to provide the thrills and chills. And the press is most obliging. In 2006 and 2007 they terrified us with Avian Flu; in 2003-4 we got the shakes with SARS; 2001-02 we saw the double-header of both smallpox and anthrax; and in 1996-97 it was Hanta virus pulmonary syndrome. The only difference this year is that the H1N1 flu is actually making lots of people sick.

**Health Care Financing Administration (HCFA recently renamed CMS [Centers for Medicare & Medicaid Services]):** The federal agency that is responsible for creating thousands of forms to send to physicians so that they may attempt to get reimbursed

**HHS (Department of Health & Human Services):** That cabinet level department of the Federal Government that ignores physicians and sets health care policy based on the public's responses to the latest quiz in *Cosmo*

**Informed Consent:** An agreement coerced voluntarily from a patient for the performance of specific medical, surgical or research procedures. The material is explained in as many multi-syllabic, jargon filled terms as possible, except for the word, "death." If the patient is not scared witless by the risk of a complication that occurs less than

**"Terms" Continued on page 13**