

Letters to the Editor

Health care in America

Conversations about the changing nature of health care in America can be complex and confusing. In “Health care in America: A right or a privilege?” (*The Pharos*, Spring 2017, pp2–8) Dr. Byyny and Dr. Tooker offer an in-depth and insightful description of this topic.

A recent analysis of studies about the effects of insurance coverage on health in America was conducted and published in the *New England Journal of Medicine*.¹ Evidence indicates that improving coverage improves health in a variety of domains including access to care and utilization, chronic care, mental health, and mortality.¹

In the current health care climate, it becomes particularly important to provide patient-centered care. As providers, we may be able to synthesize such materials and communicate salient points to our patients. The ability to explain such issues is useful in clinic, and other settings, even where we may least expect it.

A few months ago, I took a walk to a nearby dog park to play fetch with my dog, a Jack Russell terrier. “That’s a beautiful dog!” I heard someone say to me. “Thank you,” I said as I turned my head to notice an older man approaching me. He was wearing a dirty undershirt, a worn brown flannel shirt, and gray sweatpants. Slightly disheveled, he seemed to be moving slowly toward me focusing on my dog.

As he approached to pick up the clear bright blue

plastic ball I had thrown for the dog, I noticed that he bent over slowly, focusing his effort to reach the ground as deliberately as possible, wincing slightly. He grimaced just enough to reveal stained, crooked teeth.

“Didn’t they have some trees over there?” He pointed to my right, along the abutting wall to the park where offices with small windows looked directly into the park. Before a recent renovation, the park had several large rows of plants for privacy.

“You’re right. There were a bunch of them right along this wall where the offices are, but I think they got rid of a lot of them when they remodeled the park,” I said.

“Too bad...I used to sleep there, right behind some,” he said. He looked at the area, almost nostalgically.

Sensing he was open to sharing, I decided it would be okay to ask a few questions. “Where do you sleep now?” I asked, almost as if taking a social history.

He was previously homeless, moving from state to state to try and secure a steady source of income as a truck driver. When he finally returned to Boston, he settled down in a one bedroom apartment he shared with two other men. He had a host of medical problems including two “clogged” arteries in his heart, and a “really bad back.” His most pressing issue was that he needed dentures.

I found myself wanting to ask specific, practical questions about his access to health care. I also wondered what he knew about his own ability to obtain medical services.

“Do you have Medicare?” I asked.

He looked at me puzzled that a stranger would ask such a question. Slowly, we began to talk about services he needed. I asked simple questions and listened. Eventually he asked if I was in health care. When he learned I was a doctor, he was thrilled. He seemed to have a lot on his mind. He wondered if his insurance would cover these services, and if he could afford them? Was there a chance he may lose his coverage? Where could he go to ask more questions?

I had recently spent several days in lectures listening to experts discuss the intricacies of health care in the United States, and strategies to improve value.² Health care in the U.S. is challenging enough for most well informed health care providers that take classes, watch the news, and read medical journals. But, as we try to understand these topics in an ever-changing, tumultuous landscape, how are our patients going to fare?

From its enactment in 2010, the Affordable Care Act (ACA) has faced almost continuous assaillment, the most recent being repeal and replace, rather than more constructive efforts to renovate and revise. Even President Obama acknowledged that more work is needed to improve what currently exists.³ Although the implementation of the ACA possessed limitations,⁴ it expanded coverage for approximately 20 million people.³

Regardless of political disposition, physicians must be equipped to help prepare patients for changes. There is confusion for everyone as to how this process may impact coverage and how policies will impact things like drug benefits and public health projects.⁵ Providing patient-centered care means helping patients comprehend upcoming changes. Yet, trying to decipher the political and medical consequences of different health care proposals is arduous.

The man in the park was thankful for having someone listen to his concerns. Though superficial and basic, my explanation of Medicare, and a brief chat about of what could happen to health care, was hopefully helpful to him. He agreed to meet with a social worker as a way to get connected to additional resources.

I wondered, had it not been for the recent health policy courses I took, would I have been able to give him salient advice? Just a few months earlier, I'm not sure I would have been able to help him.

He appreciated the suggestion to find improved Part C coverage with the hopes that his dental work, a full-mouth extraction with dentures, may be covered. For him, it was not just a cosmetic issue, but one that impacted his ability

to speak, to eat, and to live a normal life.

I left feeling confused, wondering how well I would be equipped to answer these questions for future patients. For many though, there is no opportunity to even ask, or they are unsure what to ask.

I thought about how we will prepare medical students, residents, fellows, and clinicians with the knowledge on how to support patients in these uncertain times. It became clear that medical care alone would not restore this man to health, but at least protecting his access to care is essential. Providing him with the knowledge and resources to see a primary care doctor allows him to focus on his health longitudinally, and to benefit from the value of incremental care.⁶ Yet, few physicians have access to the resources in the community that would do more to give this man a state of health that would allow him to work and live independently.

This is an unprecedented time of change in the U.S. health care system. There is an element of deep disarray, overlaid with a continuous stream of news headlines, that makes this challenging to grasp for our patients. This is particularly true for those with limited health literacy and socioeconomic status. We should remember to focus on the patient, providing them with the unique resources they might need. Thinking about ways to “flip” the conversation and ask, “What matters most to you?”⁷

As we move forward, many patients will need help understanding changes to their health care, and we should communicate with clarity, providing explanations to orient patients and allay their fears in a practical way to mitigate confusion. Many such conversations will take place in the hospital, while others may happen in less common settings, like the dog park.

We must remember to realign with core goals—to improve the patient experience, improve population health, and lower costs.⁸ Amid the flux of our system, focusing on providing patient-centered care, and communication are vital.

Matthew Mossanen, MD
AΩA, David Geffen School of Medicine at the University of California, Los Angeles, 2010
Boston, Massachusetts

References

1. Sommers BD, Gawande AA, Baicker K. Health Insurance Coverage and Health—What the Recent Evidence Tells Us. *N Engl J Med.* 2017;377: 586–93.

2. Porter ME, Lee TH. Why strategy matters now. *N Engl*

Letters to the Editor

J Med. 2015;372(18): 1681–4.

3. Obama B. United States Health Care Reform: Progress to Date and Next Steps. JAMA. 2016;316(5): 525–32.

T 4. Oberlander J. Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform. J Health Polit Policy Law. 2016;41(4): 803–26.

5. Oberlander J. The End of Obamacare. N Engl J Med. 2017;376(1): 1–3.

6. Gawande AA. The Heroism of Incremental Care. The New Yorker. January 23, 2017. <http://www.newyorker.com/magazine/2017/01/23/the-heroism-of-incremental-care>.

7. Bisognano M, Schummers D. Flipping healthcare: an essay by Maureen Bisognano and Dan Schummers. BMJ. 2014;349:g5852.

8. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff (Millwood). 2008;27(3): 759–69.

The genomic revolution

Dear Dr. Neaves,

I read with interest your recent article “The genomic revolution and its implications for medical practice,” in *The Pharos* (Spring 2017, pp21–27). While I embrace many of the concepts described therein, I am troubled by the male bias used in the article’s text and images. To discuss chronic myelogenous leukemia and not mention 1998 Lasker awardee Janet Rowley (AQA, University of Chicago, 1994, Alumnus) is a profound oversight. Her seminal papers in *Nature* (1973), and the *New England Journal of Medicine* (1973) are landmark findings.

Additional examples that could, and should, have been used:

- Barbara McClintock, Nobel Laureate, transposable elements
- Mary Claire King, cancer genetics
- Xandra Breakefield, neurogenetics
- Elaine Mardis, genome sciences/sequencing
- Deb Nickerson, exome/genome sequencing
- Christine Seidman (AQA, George Washington University, 1978), cardiac genetics
- Helen Hobbs (AQA, Case Western Reserve University, 1978), lipid genetics
- Emmanuelle Charpentier and Jennifer Doudna, gene editing

Each of these great scientists has made deep and lasting marks on the field of genetics.

It takes conscious effort to overcome bias, but such an

effort makes us better physicians and scientists.

Thank you,

Elizabeth McNally, MD, PhD

Director, Center for Genetic Medicine

Northwestern Feinberg School of Medicine

Chicago, Illinois

AQA, Albert Einstein College of Medicine of Yeshiva University, 1990

Dr. Neaves’ response

Dear Dr. McNally,

You are right, I sincerely regret failing to take the opportunity provided by *The Pharos* to acknowledge Dr. Rowley and others you noted.

Thank you for writing,

Bill Neaves

AQA University of Texas Southwestern Medical Center at Dallas, 1990, Faculty

Editor’s Note:

The images used to illustrate Dr. Neaves’ article were selected by the editorial staff of *The Pharos*.

Dachau ashes

The story of the Dachau ashes (“Hidden away for seven decades: The identification and interment of ashes from the Dachau concentration camp,” *The Pharos*, Winter 2017, pp42–47) is highly moving. I especially appreciated the rabbinical thinking regarding their disposition. As Michael Israel noted, the whole sequence of events was highly unlikely. However, there is also a highly unlikely set of events regarding the liberation of Dachau.

The 45th Infantry gets the official credit for liberating Dachau, but it was a huge complex, with multiple sub-camps, and different units got to the subcamps first. The 522 Artillery was a forward unit, and the men were horrified when they came upon bodies—living and dead—lying in the snow along the road.

More than 5,000 prisoners had been forced on a death march as the Allies approached, many dying along the way or shot as they became too weak to continue. The 522nd set up a field hospital for them, and also liberated a sub-camp. Disobeying orders to wait for backup, they shot off the lock on the gates so they could get to the emaciated inmates.

They are known as the “Unlikely Liberators” because

they were a segregated unit, Japanese-Americans from Hawaii and California. They were American citizens treated like enemy aliens—many had been in internment camps just on the basis of their ethnicity, and their families still were living in the camps in the United States. Despite the shameful treatment, thousands volunteered to demonstrate their loyalty.

A persecuted minority liberated another persecuted minority.

They were ordered to not speak of what they saw and did there, and the government kept no record of their actions there. It wasn't until more than 40 years later that the true story emerged from books by, and interviews with, Dachau survivors; and 522nd survivors and the photos they had taken.

Eric Saul, former curator of the Military Museum of the Presidio in San Francisco, researched it all and created a photo exhibit telling the story of the 522nd and the

Dachau survivors they encountered and helped. Called "Unlikely Liberators" it has been exhibited at Yad Vashem in Jerusalem, Washington, DC, and various cities across the U.S. In the photos the soldiers were as anonymous as the Dachau inmates—until the exhibit came to Honolulu.

Exhibited at Temple Emanuel, the photos soon had names for most of the soldiers, provided by some 522nd survivors, their families, and friends. During the High Holy Days services, there were special prayers for the 522nd and the 100/442RCT, all Japanese-Americans who fought the Nazis in Europe, and endured prejudice in the U.S. There were also prayers for those who suffered in the camps.

Hawaii is the one state where all ethnic groups, including Caucasians, are a minority, and our former president is just another *hapa-haole* (half white).

Cynthia Burdge, MD

AQA, Rutgers New Jersey Medical School, 1985

Kailua, Hawaii

Information and cognitive overload

In the Autumn 2016 issue of *The Pharos* (pp2–11), Richard L. Byyny, MD, discussed a serious and growing problem in "Information and cognitive overload: How much is too much?"

The distraction factor posed by too much information has damaged the way that doctors interact with patients. It has worn thin their mental and physical stamina, making it difficult to listen well to patients and to do a good exam.

Information overload has made being cordial with patients and showing empathy almost impossible.

Primary care doctors are uniquely susceptible to this problem. Their day is continuously interrupted by lab reports, consultation reports, emergency room reports, requests from visiting nurse and home health agencies, and the endless flow of telephone calls from patients.

Is it any wonder that burnout and dissatisfaction run so high in primary care?

I deal with this problem by limiting the number of patients I see. I don't take on new patients. I no longer go to the nursing home, and I use hospitalists.

I am still busy and experience periods of burnout. Although my income has decreased considerably, I consider it a fair trade-off for maintaining the equanimity and peace of mind that I need and that my patients expect.

Edward Volpintesta, MD

Bethel, Connecticut

The tragedy of medical ethics

In his recent letter to the editor, former Colorado Governor Richard Lamm eloquently describes the costly paradox of unfettered medical spending on the individual patient at the expense of greater societal needs (*The Pharos*, Winter 2017, pp 58–59).

Physicians in the United States place the health of the individual patient as the ultimate priority in the medical decision-making process. This approach is based on the Hippocratic Oath; our society's domineering cultural principles of freedom and autonomy; the burden of scrutiny by "quality" monitors; and an aversion to accusations of medical malpractice.

I am a practicing critical care physician in Colorado. In our ICU I am caring for a relapsed, non-compliant patient with myriad complications of alcoholic cirrhosis; a nonagenarian, paralyzed, stroke victim; and an elderly man with myeloma kidney about to embark on hemodialysis. Each and every day I provide expensive attention to individuals who disproportionately utilize societal resources.

Where does Governor Lamm suggest that we begin his "painful process of practical trade-offs with winners and losers"? Does he have any specific suggestions? Are politicians and bureaucrats able to offer any real insight, guidance, or even some small measure of protection in that regard?

Charles J. Van Hook, MD

AQA, University of Wisconsin School of Medicine and Public Health, 1985, Faculty

Longmont, Colorado

The tragedy of medical ethics

In his recent letter to the editor, former Colorado Governor Richard Lamm eloquently describes the costly paradox of unfettered medical spending on the individual patient at the expense of greater societal needs (*The Pharos*, Winter 2017, pp 58–59).

Physicians in the United States place the health of the individual patient as the ultimate priority in the medical decision-making process. This approach is based on the Hippocratic Oath; our society's domineering cultural principles of freedom and autonomy; the burden of scrutiny by "quality" monitors; and an aversion to accusations of medical malpractice.

I am a practicing critical care physician in Colorado. In our ICU I am caring for a relapsed, non-compliant patient with myriad complications of alcoholic cirrhosis; a nonagenarian, paralyzed, stroke victim; and an elderly man with myeloma kidney about to embark on hemodialysis. Each and every day I provide expensive attention to individuals who disproportionately utilize societal resources.

Where does Governor Lamm suggest that we begin his "painful process of practical trade-offs with winners and losers"? Does he have any specific suggestions? Are politicians and bureaucrats able to offer any real insight, guidance, or even some small measure of protection in that regard?

Charles J. Van Hook, MD

*AQA, University of Wisconsin School of Medicine and Public Health, 1985, Faculty
Longmont, Colorado*