

Readers' Forum

The North Carolina Healthcare Safety Net

To the Editor

The North Carolina Healthcare Safety Net Edition (Volume 66, Number 2) is worthy of everyone's attention, for it shows how tenuous the safety net is and how easily it can be torn further.

On reading and rereading this volume, I have not found a reference to a valuable, but overlooked resource for low-cost and excellent patient care, the retired physicians who reside in almost all of our communities.

I have spent the past 14 years as a member of the Senior Physician Services Group Committee of the American Medical Association (AMA) and have learned that many of our retired colleagues all across the country would gladly help meet the need by volunteering their services. As physicians retire earlier to escape the rigors and changes associated with medical practice today, more are available to help in the volunteer arena. We have learned, too, that after a few months to years of retirement, these healthy, experienced, and, sometimes bored, retirees are more than ready to once again don their white coats part-time and care for patients. Often, the only reason they do not offer their talents is that they are not asked.

Hilton Head Island has a splendid free clinic, which is staffed largely by retired physicians. Visit them while you are there and see what can be done. They have a complete plan for an all volunteer clinic and seem pleased to share their expertise. Several of our North Carolina communities have utilized the retired physicians as well.

The two major impediments to volunteer care by retirees have been liability and licensure. However, if one stays in the same state and has not relinquished his or her license to practice, there is not a problem as long as continuing medical education (CME) credits are maintained. As to liability, there is a recently funded legislative mandate that volunteer physicians are to be treated as federal employees in the matter of liability and, thus, are covered. The North Carolina Medical Society would likely be the best source for exploring this avenue, as there are some other provisions to be considered. Another source of information is the Senior Physicians Group at AMA.

In addition, North Carolina Medical Mutual provides a very low-cost policy, which covers the purely volunteer retiree, subject to underwriting. This has the advantage of full-time coverage, not just while working in a clinic. Kudos to Med Mutual for offering this excellent policy, for not all mutual or commercial companies offer this kind of community service coverage.



The purpose of this letter is to encourage readers to volunteer and to encourage those who need physician volunteers to ask the retirees in their area to serve. There is a wealth of talent and experience withering on the vine, and some of it is just waiting for an opportunity to be a part of the North Carolina healthcare safety net. It deserves more attention than it has been given.

*James H. Burrus, MD, FACOG
Shelby, NC*

To the Editor

Access to and delivery of quality healthcare to ALL of our people should be the goal of any healthcare system. At present, ready access is limited to the insured (corporate and self-insured; Medicare and Medicaid; veterans; and government employees, including politicians) and much less to the uninsured (more than 45 million, including approximately nine million infants and children) and many underinsured. You briefly allude to this in your introduction to the North Carolina healthcare safety net and offer a solution: "...until healthcare insurance is universal, the uninsured will remain a health policy issue of concern."

There are 1,200+ for-profit health insurers in the United States with consequent duplication of administration (CEOs, directors, employees, and stockholders), forms, and procedures amounting to about one-third (about \$500 billion per year) of the cost of our healthcare (about \$1.6 trillion in 2003 and rising 7-8% per year).

A crisis begs for action. Access and much of those insurance costs could be addressed with universal, single-payer, tax-funded (like Medicare and Medicaid and the rest of the developed world) national insurance. The overwhelming majority of our people want it, but are not heard or represented. So far, special interest politics have prevented this with for-profit health insurers each, or collectively, vigorously opposing, if not lobbying against, any change (remember the Harry and Louise ads?). If we could ever get over this obstacle, many of the other problems with the delivery of healthcare could be more readily solved.

Another problem that immediately comes to mind is the myth of perfection in medicine and the unrealistic expectation of those we serve. Ours is the most litigious society in the world (300+ lawyers per 100,000 persons compared with 50 in the United Kingdom and five in Japan), and this has led to rising defensive medicine with many unnecessary and very expensive

tests and procedures. Carefully organized mediation boards to evaluate the legitimacy of claims and awards might help. Are we driving potential students from careers in medicine with these problems?

I heartily agree with and endorse your comment regarding the need for universal health insurance. Until that is accomplished, we will continue to flounder in a sea of discontent and disservice to our people and our profession.

*Robert McLelland, MD, FACP
Durham, NC*

To the Editor

Thank you so much for your well timed and thoughtful discussion of the dissipation of the safety net for healthcare in North Carolina.

As President of the North Carolina College of Emergency Physicians, I can safely say that most emergency physicians will be surprised that there was not more emphasis on emergency departments (ED), other than an isolated comment that almost 700,000 uninsured received care in an ED in North Carolina last year. This volume might be greater than all of the other components of the safety net that you describe combined.

The ED is, in fact, the safety net to the safety net, as you describe it, which warrants additional discussion of its own. Emergency departments in the state are routinely used for non-emergent clinic problems by the uninsured who have no local clinic or are turned away from their clinic because of capacity issues. The ED is by far the most expensive place to treat these patients because the overhead of running an ED is so much higher than that of a clinic. It is naive to believe that the state and local governments do not ultimately pay for the increased cost of trying to provide this care in the most expensive environment available.

It is a profound disservice for the uninsured to try to treat many of these patients in an ED because proactive continuity of care and disease management is so badly needed to successfully manage many of their ailments. This cannot be provided in an ED.

Most ED's in North Carolina are so backed up with non-emergent uninsured clinic patients, that it has a profound effect on the efficiency and safety, never mind the convenience, with which patients with true emergencies can be managed in our EDs. On most days, any given ED has patients with significantly urgent or emergent medical problems who wait unacceptably long periods for non-emergent patients to be screened and helped however possible.

Because of EMTALA,* emergency departments cannot turn away these patients based on the ability to pay. This well intentioned federal statute ensures that all insured will have access to EDs for healthcare, but provides no funding to hospitals to provide this mandated care. The uninsured probably represent at least 25% of patients seen in EDs across the state, and much more in some areas. As you point out, these same hospitals and physicians remain vulnerable to the skyrocketing malpractice

costs associated with caring for these patients, despite providing care that is more often than not unreimbursed.

I thought it was curious that the North Carolina College of Emergency Physicians was not asked to contribute to your otherwise outstanding task force, since our constituents provide the majority of the "safety net" care of the uninsured that you describe. We would be happy to participate in your discussions in the future, if you so see fit. Thank you.

*Edward N. LaMay, MD
President, North Carolina College of Emergency Physicians
Durham, NC*

* See page 230.

To the Editor

I read the Issue Brief and Commentaries in the March-April 2005 issue of the *North Carolina Medical Journal*. These reports focused on providing healthcare to the uninsured and the North Carolina healthcare safety net.

I found the Issue Brief and Commentaries interesting. However, I was dismayed to learn that the Task Force, and Task Force Steering Committee, was without representation from North Carolina's emergency medicine specialists. More importantly, I was distressed that the critical and essential role that emergency medicine specialists play in the North Carolina healthcare safety net was not well-described, and that Task Force recommendations made no attempt to address the unique problems that care of the uninsured present to emergency medicine providers. My dismay and distress are all the more acute since using the numbers that the Task Force provided in its reports, emergency medicine specialists cared for more uninsured patients in 2003 than all other components of the healthcare safety net combined!

It is critical that North Carolina Institute of Medicine, North Carolina state legislators, and all North Carolina citizens be aware of the role emergency medicine specialists play in North Carolina's healthcare safety net. Emergency medicine specialists are the very fabric of the ultimate safety net. Providing this safety net 24 hours-a-day, seven days-a-week is part of the mission of emergency medicine. However, fulfilling this mission poses a unique set of problems that affects not only the uninsured, but every patient who needs or may need emergency care. It is absolutely essential that any discussion of the North Carolina healthcare safety net include emergency medicine specialists.

I am optimistic that as debate and discussion of the Task Force's reports and Commentaries ensue, it will be apparent that including representation from North Carolina's emergency medicine profession is an integral part of achieving better healthcare, not only for North Carolina's uninsured citizens, but for all North Carolinians.

*C. Michael Sheppa, MD, FACEP
President Raleigh Emergency Medicine, Inc.
Raleigh, NC*

Response from the Task Force Director

Drs. Lemay's and Sheppa's letters, published in this issue of the Journal, raise questions about the lack of representation of emergency physicians on the Task Force on the North Carolina Healthcare Safety Net, and in the commentaries on the special issue on the healthcare safety net published in the March-April issue. We appreciate the comments of Drs. LeMay and Sheppa, but want to assure them that the Task Force was acutely aware of the problems faced by the state's hospital emergency rooms in addressing the healthcare needs of the rising numbers of uninsured. The Task Force included several chief executives of urban and rural hospitals throughout the state, who raised these issues throughout the Task Force deliberations. While we

feel that enormity of the contribution made by hospital emergency departments to the care of the uninsured in our state were appropriately dealt with in our discussions and in our final report, we agree with Drs. LeMay and Sheppa that it would have been better to have included representation from the physicians who actually provide this care. We have included representation of emergency medicine physicians in our new Task Force that is studying ways to expand health insurance coverage to the uninsured.

*Pam C. Silberman, JD, DrPH
President Elect
North Carolina Institute of Medicine
Durham, NC*

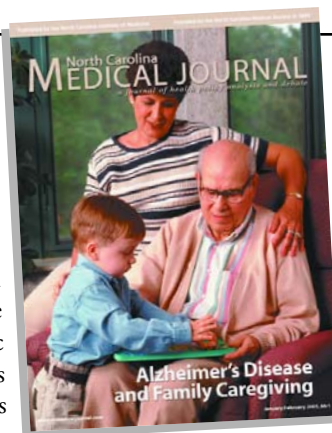
Alzheimer's Disease and Family Caregivers

To the Editor

The January/February 2005 issue of your Journal dealing with Alzheimer's disease was a truly valuable work relating to this condition. The broad range of Alzheimer's concerns from basic medical issues to socioeconomic ramifications was addressed admirably. This range of articles underscores the cruel irony that the burden of this disease is born by family, caregivers, and society at large.

Efforts to promote early recognition, diagnosis, and reasonable treatment interventions can only serve our state well into the future. Thank you for bringing this issue to publication.

*Michael J. Kushner, MD
Wilson Orthopaedic Surgery and Neurology Center, PA
Wilson, NC*



To the Editor

Please express appreciation to Myron Green for sharing his experience caring for his wife, Sadie, who has advanced dementia, in the January/February 2005 issue of the *North Carolina Medical Journal*. His capacity is remarkable, and it was a great privilege to read his description of coming to accept "... the way she is ..." and then to give her all that she needs, day after day, with steady skill and amazing grace.

Thanks also to Dr. Donald Madison, who gave us the eyes and ears to see and listen to what it is like to do this. His essay told us what we must do without lectures, facts, figures, or predictions. It put a face on Alzheimer's disease and on the remainder of the issue, which then provided a larger context for this call to action.

We must act personally, regionally, and nationally to support Myron and Sadie, husbands and wives, neighbors, parents, and grandparents. Once we accept "... the way [it] is ..." maybe we will learn and teach and act together to do what we must do.

*Lynn M. Cleary, MD
Associate Dean for Curriculum
Upstate Medical University, State University of New York
Syracuse, NY*

North Carolina MEDICAL JOURNAL

CLASSIFIED ADS: RATES AND SPECIFICATIONS

The Journal welcomes classified advertisements but reserves the right to refuse inappropriate subject matter. Cost per placement is \$60 for the first 25 words and \$1/word thereafter.

Submit copy to: ncmedj@nciom.org
fax: 919-401-6899
mail: North Carolina Medical Journal
5501 Fortunes Ridge, Suite E, Durham, NC 27713

Include phone number and billing address, and indicate number of placements, if known.