

Richard W. Snyder II, MD
President's Page

Installation Speech by DCMS President Richard W. Snyder II, MD, given Jan. 19

I want to thank the membership for the incredible honor and privilege to serve as the 129th president of the Dallas County Medical Society. As I prepared my remarks, I re-read the installation speeches of some of my predecessors. I particularly was impressed by Dr. Huber's comments about how humbled and honored he was to be elected president.

Those of you who know me well, know that I don't do humble very well. But as I reviewed on the DCMS Web site the 136-year history and role of our medical society, I realized that "honored" and "humbled" are exactly the right words. Founded in 1876, the Dallas County Medical Society now has more than 6,400 members and is the second largest county medical society in the country. For us, as the DCMS vision statement says, our vision is to promote "a healthy community." The scientific, educational and innovative healthcare accomplishments in Dallas County during these 136 years truly are awe inspiring. DCMS played an integral role in many of these successes by helping create an environment of service, dedication and innovation in the pursuit of that "healthy community." The presidents who led and shepherded the Society in these successes include pioneers and giants in our medical community.

Over the last couple months, I have been asked many times what I hope to accomplish as president of the Dallas County Medical Society. My answer is simple: I want our members to begin to feel uncomfortable. I want to get them out of their comfort zones!

We physicians are comfortable in the realms of science and education. That is our culture, and, to a large extent, the core of who and what we are. To be a physician, we have to be grounded and adept in science. And we are fairly comfortable with education. After all, the educational journey to become a physician takes an additional 7 to 12 years after college. We have to be comfortable with self-education because medicine is a rapidly, ever-evolving discipline that demands lifelong learning. But we also are comfortable with education as researchers, teachers and educators – teaching the next generation of physicians, and educating our patients and community about health, the nature of their illnesses, and treatment.

These are our comfort zones, and we practice our comfort zones of science and education daily in the exam rooms, operating rooms and hospitals. For much of medicine's history, the quality of care depended predominantly on these two pillars. The history of success of the DCMS and the Dallas medical community resulted mainly from achievements in science and education.

However, that no longer is the case. Slowly, a third element has emerged that joins science and education in determining the quality of health care we experience. No longer do statistical P values and confidence intervals, guidelines and consensus statements reign supreme in determining the types of test or treatment we can offer our patients.

COMFORT ZONE EXPANSION

I am a cardiologist, and our national headquarters for the American College of Cardiology is in Washington, DC. Etched in stone behind the front desk is the formula that represents this new reality: Quality care through science, education and advocacy. To appreciate the inclusion of "advocacy," you have to appreciate the adage of location, location, location. For more than five decades, the ACC had its headquarters in the relatively low-overhead area of Bethesda, the home of the National Institutes of Health. Five years ago it moved to the high-rent district of DC. The ACC moved from the epicenter of medical science (NIH) to the epicenter of politics (DC). This was no accident. The ACC realized that quality health care now and going forward will depend as much, if not more, on advocacy as on science and education. As the ACC grew, it became clear that to improve quality, the College would have to influence health policy.

The same realization occurred to other medical societies that now call DC home. And in Texas, it's no coincidence that the headquarters of Texas Medical Association is in Austin, and not on the campus of one of our state's fine medical complexes or medical schools. It is located in the state capital, the epicenter of our state political system, a mere touchdown pass or two from the state capitol building.

For a physician to be an advocate for patients requires much more than words. To quote the American College of Physicians Ethics Manual, "Physicians have an opportunity and duty to advocate for the needs of individual patients as well as for society." The reality is that physicians will have as much impact on the health care our patients receive in legislative chambers and board rooms as in exam rooms and operating rooms. A colleague is fond of saying, "You doctors can treat one patient at a time or a whole state or country of patients at a time by getting out and being an advocate for healthcare reform." If we physicians are serious about playing in the quality and access arenas of health care, we must advocate for positive change in healthcare policy.

Although being an advocate is not part of our training, it is a role with which we must become comfortable. Advocacy needs to become part of our culture. This is the one area where we doctors need to be more like lawyers. Now that is a scary statement, but when law students get out of law school, part of their culture, part of their genome, if you will, is that they will be active participants in the political process, regardless of their practice field.

Advocating for our patients is something for which we physicians are uniquely suited. Several years ago, a nationwide survey ranked the credibility of professions. Healthcare providers were at the top of this list, and by a significant margin over the clergy and judges. We need to leverage this credibility on behalf of our patients and society.

The stakes could not be and never have been higher. With health system reform, we are on the precipice of the most significant change in the delivery of health care since the institution of Medicare in the 1960s. Health care will consume massive resources in terms of money and providers, and we have insufficient amounts of each to meet the need. Total US healthcare expenditures average \$2.6 trillion annually and consume 17 percent to 18 percent of our GDP. About 45 percent of total healthcare spending is by federal, state and local governments. Medicare costs \$500 billion annually, which is 12 percent of the federal budget. In Texas, 35-40 percent of our state budget is devoted directly to health care, and some 20-25% percent of the state bills introduced each session are related to health care. Last session the TMA tracked 1100 bills.

The predicted physician shortage is a work force bubble that could rival the financial bubble we just witnessed on Wall Street. Today 43 percent of cardiologists are over age 55, and demographics are worse for other specialties, such as family practice and internal medicine. This is occurring just when a large segment of the population is aging into Medicare eligibility and its peak need for medical care. Every day, about 10,000 baby boomers become eligible for Medicare. Health system reform will make health insurance coverage available for 31 million people who did not have insurance before.

However, coverage is not the same as access. And access to a waiting list is not the same as access to health care. Our shared vision of "a healthy community" must include timely access to quality, cost-effective health care. The problem we face is how we reconcile the demands of our patients and society for medical certainty and affordability. These two ideals often are divergent and mutually exclusive.

The resources to meet these challenges are limited, and the supply/demand considerations are not favorable. We have more health care available in terms of tests and treatments than we can afford. If the current rate of use continues, we'll face massive shortfalls in manpower and financial resources.

The type of health care that will emerge and the type that we will experience ultimately will depend more on advocacy than on science and education. Already we are witnesses to both legislative and regulatory decisions that have had a major impact on health care that has nothing to do with a landmark scientific paper, a P value, or confidence intervals. Regardless of the expected Supreme Court decision regarding the constitutionality of our health system reform, the evolution is just beginning. Even if the

Court upholds the bill, most of the decisions are yet to be made regarding how health care will manifest, on a federal, state and county level.

We all agree that change is coming and is much needed. But there are three types of change, as any physician knows when we interview our patients. We ask whether the patient's symptoms are better, worse or about the same. We can ask the same about healthcare reform. It is debatable whether the path we are on is better, worse or about the same. Regardless, it behooves us as physicians to be involved in the process of change for the better for the benefit of our patients. As we've learned, if we're not at the table, we'll be on the menu.

Physician advocacy benefitting our patients has many forms and occurs at many levels. Healthcare advocacy plays out at the federal, state and county level, and our Dallas County Medical Society, led by our advocacy director, Tracy Casto, plays an active role in all of these. At the county level, for example, the Commissioners Court has a major impact on access to health care for the uninsured, which for Dallas County represents 30 percent of the population, or 600,000 people. The Court oversees Parkland hospital, which can care for only about half of these people. The remaining people must seek care at other private and not-for-profit community hospitals. One of DCMS' major goals this year is to build on the relationships with the county commissioners and advocate for these patients.

Healthcare advocacy also is practiced in the regulatory, judicial, insurance, and hospital arenas. All have an important impact and play a vital role. Many healthcare policy decisions are not derived from a legislature, but from a regulatory agency, such as the state and federal Department of Health and Human Services, through policy and rule making. We physicians must be involved in all these sectors.

Advocacy is a skill that is not foreign to physicians, just dormant. One time I persuaded my physician wife to accompany me to DC for the annual cardiology legislative session. She was a little reluctant, explaining that meeting with lawmakers is not something at which she excels. During the first of eight meetings with lawmakers, she sat quietly and listened. In the second meeting, she got in a few juicy sound bites. By the third, she took over the discussion, and I don't think I got a word in. Talking with our legislators and congressional representatives is as easy as that. Though I must confess, the first time your receptionist tells you the Attorney General for the State of Texas is on the phone and want so speak to you, desperate thoughts of jail time and retaining a lawyer are the first visions that shoot through your mind.

TORT REFORM FIGHT

Our physician community is fortunate to have physician advocates we can emulate. The constitutional amendment on tort reform that passed in 2002 was a fight won through advocacy, not from a scientific paper or guideline. Our reform is the envy of the country, and the model of the US House medical tort reform bill.

But tort reform would not have happened without our legislative advocacy champions at TMA and people like Dr. John Gill. He crafted the essentials of the formula on a napkin at 2 a.m. in a state senator's Capitol office. Again, no P values or scientific papers played a role.

Before tort reform, only two medical malpractice carriers were left standing in the state. Two thirds of the state's 254 counties had no obstetrician. In Dallas County, Methodist Dallas Medical Center closed its neurosurgical program and exited the Level 1 trauma system because the state's hostile med mal environment drove the neurosurgeons from the state. At Medical City, my own hospital, our CV surgeons' coverage was cancelled on 30 days' notice because their carrier was leaving the state. This same surgical group had been featured in USA Today the year before for having the best one-year transplant survival rate. Yet they had to resort to getting med mal insurance on a day-to-day basis for an entire month. And for an entire month, if I approached a surgeon about a patient who needed a bypass, the surgeon told me, "I don't know yet if I have insurance tomorrow to help you." Patient care and patient access were impacted significantly by factors that had nothing to do with science or education.

I see examples of physician advocate heroes who have put in countless hours serving their community in Drs. Lee Ann Pearse, Craig Callewart, Tillman Hein, Lisa Swanson, and Steven Hays. These people are my inspiration and role models from whom I learn continually. But we need more of these role models. We need to get more physicians out of their comfort zones and advocate for their patients in order to pursue DCMS' vision statement of "a healthy community." We need to make places like the Capitol building in Austin as familiar as our own hospitals, and legislators like Pete Sessions as familiar as our own patients

CHALLENGES IN 2012

Once these physicians are out of those comfort zones, what issues do we want to confront in 2012? Our challenges are numerous and involve adverse economic, administrative, regulatory, and political forces. Some are so menacing, so anxiety provoking, that we do not dare speak their proper names; we refer to them by abbreviations or as acronyms. They are familiar to most of us: SGR, PPACA, ACO, HMO, UPL, CMS, MedPAC, RUQs, and RACs. Perhaps the most menacing is the deceptively benign sounding IPAB (not to be confused with an iPad, but it may be just as ubiquitous and ever much the game changer, although not for the better). The Independent Payment Advisory Board will homogenize how we evaluate and treat our patients. The unique relationship between physician and patient will be rendered almost meaningless and replaced by a third party.

Other obstacles to care that we will want to tackle involve pithy buzzwords and expressions such as medical loss ratios, economic credentialing, cost conundrums, appropriate use, and regional disparities of care. Emerging local challenges include the recently approved Medicaid 1115 waiver and the uncertainty this waiver has created in the use of up to \$250 million federal dollars per year by Dallas hospitals. These dollars had been used to offset some of the cost to care for the uninsured and Medicaid patients in our county. The uncertainty about how these dollars will be used can have a major impact on how Dallas hospitals care for these populations, especially with the expected explosion of Medicaid populations envisioned with healthcare reform in 2014.

DCMS will be involved in significant and innovative projects in 2012. The Society will expand its use of social media to connect with the membership through Facebook and Twitter, not only by CEO Michael Darrouzet but also by the president. Another exciting project will be the emergence of the North Texas health information exchange, which will go online around summer time. DCMS is a pioneer of the 13-county information exchange that will allow the exchange of basic healthcare information across hospital and physician providers. The HIE will improve quality of care while decreasing cost by limiting unnecessary duplication of tests and admissions. The innovative Project Access Dallas, operated by DCMS, ironically may benefit from the Medicaid 1115 waiver by becoming eligible for significantly more federal dollars. This could enable explosive growth in PAD and allow it to greatly expand its mission of caring for the working poor.

Perhaps no acronym or buzz word will generate as much attention in 2012 as the evolving concept of physician-hospital alignment. This relationship between hospitals and physicians is reflected in a spectrum of models, from the employment model to the physician-hospital ownership equity models, with numerous variations and permutations in between. Tighter physician hospital alignment is believed to be a prerequisite in re-emerging capitation models of reimbursement, such as ACOs, as proposed under health system reform. Improving the alignment between physicians and hospitals is thought to result in greater coordination of care, thereby improving quality, decreasing errors and redundancy, and lowering costs. I think all parties agree that greater physician-hospital association, no matter what the model, is beneficial, will improve quality and will lower costs. But we must be careful. In discussions of relationships and models of physician-hospital integration, we must never lose sight that our ultimate alignment is with the patient. The physician-patient alignment is a relationship that must never be

supplanted, never superseded, no matter what model of healthcare delivery is in vogue. We must always advocate that the alignment between the physician and patient reigns supreme.

With that I again thank the members and staff of DCMS for this honor and privilege. Despite considerable adversity, through the Society and through our roles as scientists, educators and advocates for our patients, we have much opportunity. Timely access to quality, cost-effective health care is within our reach, and our shared vision of a healthy community is in sight.