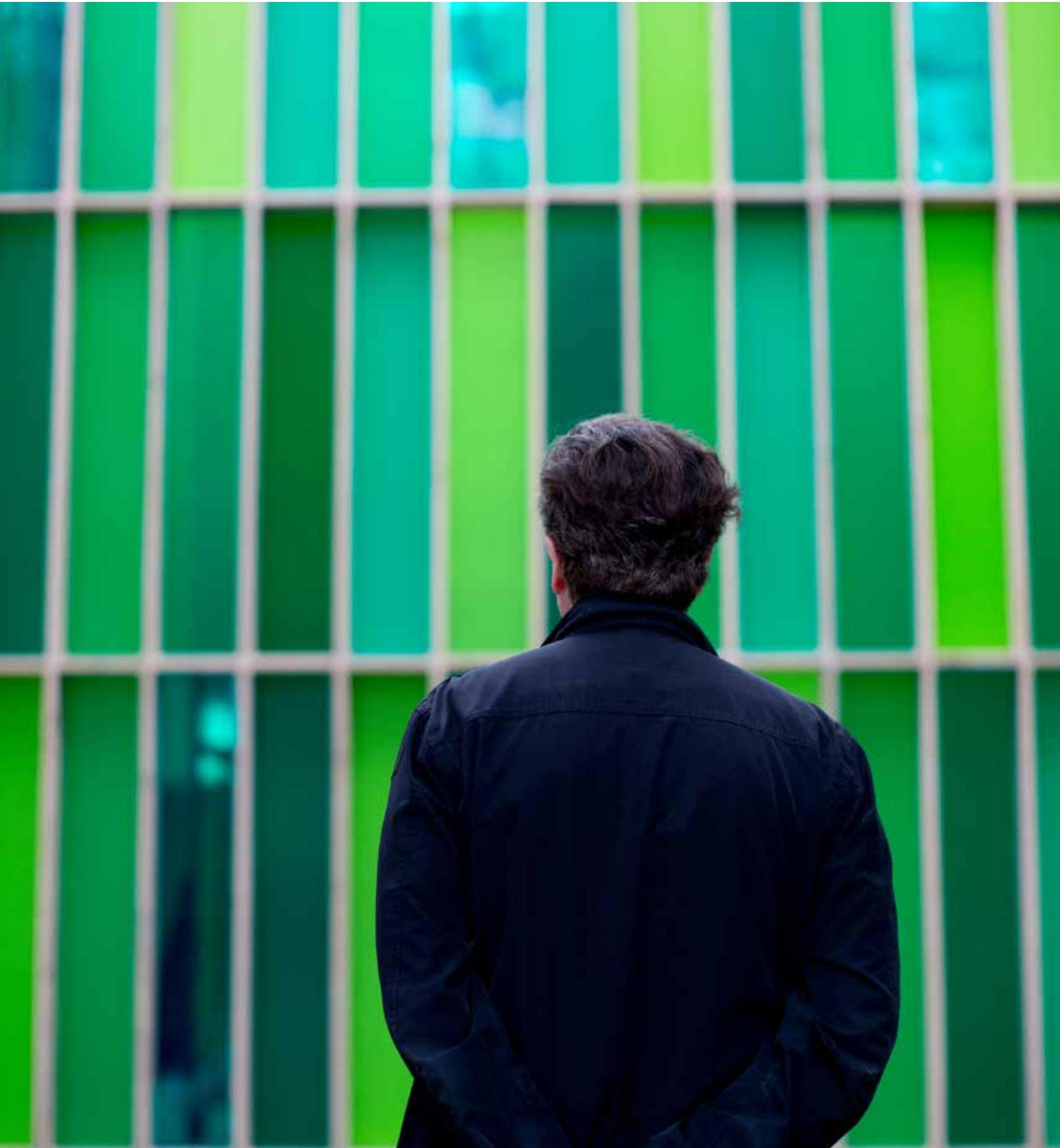


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## President's Speech

by Todd Pollock, MD

*Remarks presented at the DCMS Installation dinner on January 23, 2014.*

I am deeply honored and humbled to be installed as the 131st president of the Dallas County Medical Society. Over the last several months, I have spent considerable time thinking about what I will be dealing with over the next year. There is little doubt that unanticipated challenges will pop up, such as the West Nile Virus epidemic that hit our area in 2012 that occupied countless hours of then-President Rick Snyder's time or the difficult decision to discontinue the successful Project Access Dallas program because of funding issues.

What anticipated events are coming down the road in 2014 that will affect the practice of medicine in Dallas? The new Parkland will be nearing completion and the efforts will continue to improve the care given in this integral piece of the Dallas healthcare system. We'll face implementation of the 1115 waiver and its effect on the distribution of millions of healthcare dollars into the medical community. Probably the most overwhelming effects on the practice of medicine in Dallas, in Texas and in the nation as a whole will be the consequences of the implementation of the Affordable Care Act (ACA).

No matter on what side of the politics you fall, there is no debating that the ACA will have a profound effect on the practice

of medicine in this country. This vast and far-reaching law will have effects that are predictable and many that are unforeseen. I anticipate that the law's implementation will be looked back on as the focus of Dallas health care in 2014, and the repercussions will be felt most at the local level by the end users — the physicians and patients. The predictable positive effects, such as coverage for those with pre-existing conditions, extension of dependent coverage, elimination of lifetime limits, coverage for preventive care, and expansion of coverage to millions of uninsured, are difficult to argue with, at least on the surface. The Dallas medical community likely will face a great number of challenges and we must be prepared to navigate, adapt and, hopefully, conquer as the new healthcare landscape unfolds. My hope is that DCMS will make itself a valuable asset to its members in responding to these anticipated and unanticipated challenges.

### The Challenges

So, what challenges of Obamacare might we anticipate? And yes, you heard me right, I called it Obamacare. Not out of disrespect — I just find “affordable care act” ironic as I can't see how this law isn't going to make health care much more costly. This brings me to the first challenge — cost. The woes of the dysfunctional \$600 million website are only the first symptom. Insurance premiums generally have gone up for 2014 and are expected to go through the roof in 2015. Copays and deductibles also are on the rise, leading to more out-of-pocket expenses for our patients. Millions of insureds have been dropped from their plans as a function of cost. Those who are shopping the exchanges are experiencing such sticker shock that the government blocked viewing of the premiums until the users register. Because of these high premiums, many people who always have had health insurance are considering paying the “penalty” (or “tax”) and going without coverage. Numerous new taxes and fees have been implemented. One of note is a tax on medical devices, which no doubt will be passed on to the consumer and stifle innovation. The costs are endless, and it is hard to believe that the economics are sustainable.

Another major challenge will be in understanding this complex system with a myriad of new rules and regulations. Patients expect their physicians to have an intimate understanding of the system. And yet, studies have shown that physician understanding is only marginally better than the public's. This isn't surprising when the ACA bill is thousands of pages of legalese, and the regulations — most of which have yet to be written — will fill more than ten times that. It is this disconnect in information that is generating fear among physicians as well as our patients. This lack of understanding will result in frustration and worry, and even has spawned a cottage industry of fraud where everyone is a potential victim. The TMA has set up the “Hey, Doc” web-based video series to educate physicians on questions they may face from their patients. It is my hope that DCMS will join TMA in taking a leading role in educating our members.

I also am concerned about patients' access to care. As physicians, we understand that just because you have an insurance card doesn't mean you have access to care. Medicaid expansion may give health insurance to millions of people previously without, but those new enrollees may find few doctors who accept their plan because of the poor reimbursement and the inherent bureaucratic nightmare. For now, Texas is taking a pass on Medicaid expansion. But political pressure is rising. Recent surveys show that only 19 percent of Texas physicians take new Medicaid patients, and that number is falling. Patients who are participating in the exchanges may have trouble as well, as networks are limiting their numbers of physicians and hospitals in an attempt to keep costs in check.

Additionally, for most exchange plans that have released their reimbursement figures, those numbers are, at best, disappointing, which further inhibits physician participation. The DCMS board of directors is anxious to find ways to reach out to those in need. Programs such as DCMS CARES are in place, and from the ashes of Project Access Dallas, a Blue Ribbon Task Force for the Underserved has been formed to develop strategies for providing healthcare access to those in

need.

A significant shortage of doctors, especially primary care physicians, has been forecast. This doesn't take into account the number of physicians who will retire early, many influenced by the new healthcare law. In a recent survey, 42 percent of physicians said that the new law would influence them toward early retirement, and nine out of 10 physicians would not recommend medicine as a career to their children. This is a sad commentary on our attitudes toward our noble profession. Texas may have some buffer to this trend, as we have seen large numbers of physicians migrating to our state for its favorable economy and malpractice reform efforts.

### My Perspective

Now, I am a plastic surgeon, and although I perform reconstructive surgery and other insurance-covered procedures, my practice has a greater proportion of cosmetic, self-pay patients. My practice is not as directly affected by these systemic changes as the practices of most of my colleagues. So, what can I bring to the table as the president of this organization? What experience and perspective can I have that may be helpful in these changing times? This was the question I asked Stephen Ozanne, chairman of the DCMS Nominating Committee, when he called on me to take this position. That was the question I asked outgoing president Cynthia Sherry. It was the question I asked my father, and it is the question I continue to ponder myself.

The realm of cosmetic surgery is a microcosm of medicine and one of the few examples of how the healthcare marketplace behaves in a free-market environment. It is surprisingly little studied, as best I can tell, by economists and business academics. But it probably would have been wise for those crafting the ACA to have taken a closer look. From 1992 to 2012, the price of medical care in this country rose 118 percent, while the cost of all goods and services increased 64 percent. Compare this to the cost of cosmetic surgery, which rose only 30 percent — a relative decrease in price when adjusted for inflation.

How is that possible? Although more than 90 percent of healthcare dollars are

paid for by someone other than the patient, in cosmetic surgery patients pay for these services themselves. This skin in the game (pun intended) incentivizes patients to compare prices, seek second opinions and educate themselves on their options. This leads to competition in the marketplace. These competitive pressures have kept prices in check and spurred innovation.

This isn't isolated to cosmetic surgery. Other fields in which the consumer has a financial stake show the same pattern. For example, Lasik prices have fallen 20 percent since the procedure was introduced in 1999. Falling prices prompted innovation, resulting in new procedures such as Custom Wavefront technology with far improved quality. But the ACA has taken the medical marketplace in the opposite direction, and time will tell if this will be successful. Sadly, history — and economics — is not on the side of Obamacare.

If we can't take an economics lesson from cosmetic surgery, perhaps other lessons inherent to the field are relevant. None of these characteristics is exclusive to plastic surgery, but each is integral in the specialty's history and practice. One of the first things that comes to my mind is introspection. Whether it is the way an individual suture is placed, technical aspects of how an operation is performed, or even the performance of a front office process, one must continually and honestly assess how and what one is doing and consider ways to improve. Honest introspection leads to innovation, another distinguishing characteristic. Plastic surgeons always have been known for innovation. Examples include the likes of organ transplantation, microsurgery and wound healing. Search for new ways to make yourself, your practice and your field better and more efficient. As an example, to fill a need for more flexible OR time, plastic surgeons have led the way in office-based surgery and, in doing so, have mastered the art of practicing cost-effective medicine. Ask my scrub nurse, who watches with amusement as I struggle to get the most out of each strand of suture.

Probably the most important lesson I can share is to take the time and effort to develop a true relationship with your patients. This

is the aspect of modern medicine that has deteriorated under the current system and will worsen under the new one. Insurance companies and government are wedges that have insinuated themselves between us and our patients. Physicians are affected through the stranglehold of bureaucracy, regulations and diminishing reimbursements. Patients are facing new rules, higher out-of-pocket expenses, and restrictions on the physicians they are allowed to see. Despite these obstacles, Gallup's annual poll of trusted professionals consistently ranks "medical professional" at the top. Among all of the frustrations and challenges of our healthcare system, patients still highly value the patient-physician relationship. We cannot lose sight of this amid the sea of paperwork and regulations. So, when you enter the exam room, move your focus from the chart or computer screen, and give your attention completely to your patient. Foster that special relationship that we are uniquely privileged to share. This simple act will go a long way toward demonstrating that you are the patient's advocate and not just another bureaucratic impediment for him to negotiate to get the care he seeks.

As a final thought, I want to quote J.E. Miller, MD, a DCMS past president, who wrote in his October 1965 president's page regarding the new Public Law 89-97 or the "Health Insurance for the Aged Act" that Congress had just passed.

Only time will tell us the effect of this "Medicare" law on the American public, on physicians and the practice of medicine. We must not, and I repeat, must not exclude ourselves from exerting our influence as physicians and citizens on the provisions and effects of this law... Government can never be capable of caring for the ill. Only the medical profession can do this.

Nearly 50 years later, these words could not be more true. **DMJ**

*Todd Pollock, MD, was installed as the 131st president of the Dallas County Medical Society on Jan. 23, 2014, at Park City Club.*