Leadership Training: Working with Media

Op-ed and Letter to the Editor Guidelines:

- Keep it short! Fewer than 200 words for a letter to the editor, or 600 words for an op-ed.
- Use your voice as a doctor, patient, parent, etc. Lead with a story about a personal experience.
- Tie your piece to a current news story or local official.
- Use statistics, but provide links to current, credible sources.
- Submit your piece in body of email (no attachments!). Include contact info and brief bio.
- Review the publication's specific guidelines, usually found in the "contact us" website page.
- Contact clare@pnhp.org for help with editing and submission.

SAMPLE OP-EDS:

Why I'm the last happy doctor [586 words]

By Marsha Fretwell, M.D.
The Charlotte Observer, September 26, 2017

When I retired at 70 years old as a practicing geriatrician in Wilmington and said farewell to my medical colleagues, I slowly began to realize that I might be "The Last Happy Doctor" in town. Why is this and how did it happen? First, let me lay out some of the realities of practicing medicine today.

The surgeon general has declared that, second only to opioid addiction, "burned out" physicians is our most critical issue in health care. In a recent survey of N.C. physicians, the most prominent reason given for their "burnout" was erosion of clinical authority and the requirement of excessive insurance paperwork in order to get paid. Only 11 percent of physicians felt they had the time they needed to provide the highest standards of care. In the next one to three years, 44 percent plan to cut back on direct delivery of care, retire, or seek work in non-clinical jobs.

So, how did I end up as the "Last Happy Doctor"? It was a series of responses I made as the insurance industry began to reshape health care as a for-profit efficiency driven business. The first choice was to resist reducing the time spent with my patients. When I refused to schedule less than one half hour per patient, it became obvious that I would need to start and manage my own practice. Because of my choice to focus primarily on caring for older patients, my revenue stream was approximately 96 percent Medicare funded. Unaware, I had wandered into a "Medicare for All" financed healthcare practice.

Knowing that all my patients had coverage was a great relief to me and my office staff. That allowed us to focus on truly caring for and about them. Having a predictable reimbursement allowed me to create a budget. The greatest bonus was the lower overhead. Because my practice did not need to spend hours on the phone with agents of the for-profit insurance companies, I could hire fewer staff. Additionally, not only was I making clinical decisions based on patients' needs, I got to decide on clinician-friendly computer software for data collection. This reduced the other major reason physicians are "burned out" and leaving practice: spending excessive time using computer software that does not actually serve any meaningful purpose for clinical care.

The introduction of widespread for-profit insurance financing of health care in the 1970s is a major factor in the demoralization of physicians. The percentage of the health care insurance market served by

for-profits rose from 16 percent in 1981 to 65 percent in 1997. In the for-profit setting, physicians are required to care for patients under constant time pressure and with the knowledge that the cost of care may send their patients into bankruptcy. This model does not work in health care at the practitioner level because it requires reduction of human contact time. Without this human contact, a loss of satisfaction occurs for both the physicians and patients. Critical to the discussion is the significant lowering of survival rates and desired patient outcomes since 1950, all in the context of rapidly rising costs.

In a humane society, universal health care is a given, and those involved in health care optimally come with a calling. Helping individuals improve their health requires trusting relationships over time. Creating a “Medicare for All” financing system and removing for-profit insurers from the equation is an appropriate pathway to less expensive care, better health outcomes, happier patients and happier doctors. I know because I have been there.

The advantages of getting sick elsewhere [596 words]

By Louis Balizet, M.D.
The Pueblo (Colo.) Chieftain, June 17, 2017

Last month, a Pueblo woman, while on vacation far from home, developed chest pain, cough and shortness of breath.

She had had blood clots in her lungs previously, and feared a recurrence of this potentially deadly condition.

An ambulance was called and arrived in 20 minutes, having been dispatched from the local hospital. This was soon followed by another vehicle carrying a doctor, who assessed the woman inside the ambulance.

Her physical examination revealed severe bronchospasm (tightening and narrowing of the air tubes in the lungs). Medicines to reverse the bronchospasm were administered via nebulizer; an EKG was done; and the ambulance driver was directed to proceed to the emergency room, where another doctor assumed care. Blood tests, a chest X-ray, and a follow-up EKG were performed.

The emergency room doctor concluded that the woman's condition was due to severe asthmatic bronchitis, with recurrent lung clots ruled out by one of the blood tests. Intravenous steroids, intravenous antibiotics and additional nebulizer treatments were administered.

After seven hours in the ER, the woman's condition had improved, but not enough to permit discharge. She was admitted to an adjacent six-bed observation unit, where a third physician (like the first two, a woman) took over, and continued the regimen started in the ER.

After 12 hours in the observation unit, she had improved enough to be discharged, with prescriptions for oral steroids, oral antibiotics and asthma medicines to be administered by nebulizer.

After she was settled back in her hotel, the woman's husband went to a nearby pharmacy and walked out 10 minutes later with her medicines and a rented nebulizer. The woman gradually improved and after four days was able to resume her vacation schedule.

The bill for the ambulance and hospital services, including all tests and physicians' fees, was $137. The pharmacy bill came to $38; for locals, there would have been no charge.

In what fantasy land did this episode take place? It was no fantasy -- it was Italy. I know, because the woman is my wife.

Why was my wife's care not accompanied by a backbreaking and complicated bill, as it would have been here in the U.S.? Because Italy, along with every developed country except ours, has made a societal decision that needed medical care should be provided to all residents without crushing financial

consequences to the sick person, and that the national government should guarantee, finance and organize this care.

The efficiencies that result enable Italy to cover everybody for a fraction of what we pay with equal, if not superior, outcomes.

Italy spends $3,272 per capita for medical care; we spend $9,471. Italians have a life expectancy of 82 years; ours is 79. At an individual level, my wife's care in Montepulciano, Italy, was at least equivalent to what she would have received in Pueblo.

Since a system like Italy's (or Canada's, or Australia's, or Germany's) is so superior to ours, why don't we change?

Despite the perils for individual patients, there are some that are doing very well under the status quo -- chiefly medical insurers and pharmaceutical companies. These entities enjoy privileged and protected status in the American system that they don't elsewhere. They also have the political, financial, and public relations resources to thwart any move to a system that favors them less.

With Obamacare threatened by internal structural weaknesses and external political attacks, we should be looking for alternatives. Other countries, like Italy, offer guidance about how to achieve universal, economical and effective medical care.

Our health care debate would profit from "A Taste Of Italy."

I'm a Kansas City doctor in Australia. Trump is right about Australian health care [613 words]
By Marie Shieh, M.D.
The Kansas City Star, May 27, 2017

President Donald Trump, I heartily agree with you when you told Australian Prime Minister Malcolm Turnbull, "You have better health care than we do."

You see, I have been both a patient and a doctor in the U.S. and Australia. After working and studying as a family physician in the U.S. for almost 20 years, I landed my dream job working in Australia in 2015. I love working within this excellent health care system where doctors and patients are supported by a program called Medicare. It is similar to American Medicare but covers every Australian of every age for most health care costs.

Patients pay a small out-of-pocket fee, based on income, for things like medications ($7-$30), doctor visits ($0-$30) or X-rays ($0-$40). As their primary care physician, I can decide to charge a copay (children and seniors are always free) or stick with the basic Medicare reimbursement. For example, I might not charge patients I feel might not return for a follow-up visit. The choice is mine. Unlike working in the U.S., I never worry about bringing people back to the office to be sure they are getting the best care.

My Australian patients are not afraid to come see me and get tests done. They can visit physical therapists, dietitians, exercise physiologists, diabetes educators, chiropractors, podiatrists and osteopaths. I do not worry about patients not being able to afford an electrocardiogram, blood tests, radiology tests or medications like I did in the U.S. I can send my Australian patients to the hospital and emergency room, and unlike in the U.S., they are not afraid to go for fear of medical bankruptcy. The hospitals here are of excellent quality.

My Australian patients get care when they need it, not when they can afford it. By contrast, my American patients would routinely avoid care and treatments for fear of cost, leading to complications and extended sickness.

Australian Medicare provides high-quality, compassionate care to the elderly and disabled, which allows my patients to live with dignity at home, not in nursing homes. Take two of my patients, an elderly couple:

The husband is 90 years old and the wife 81 years old, with mild dementia. They receive regular home visits from nurses who conduct assessments and dispense medication. They might get a cleaner every two weeks if they cannot get down to scrub floors or bathtubs. And speaking of bathtubs, they get handrails installed for a substantial discount, to keep them safe from falls. These common-sense measures keep patients healthy and cut down dramatically on hospital costs.

My Australian patients with advanced or terminal illness get home visits from me if they are too weak to come to the office. They receive palliative care in their homes, on par with the best treatments I have seen in U.S. hospice care.

Compare this to my experience as a patient in the U.S. I had my first baby in 1992 while in medical school. Even though I carried insurance and enjoyed a normal, unmedicated delivery, we got hit with a bill that was five times our monthly rent. Instead of enjoying our first weeks home with our new son, we spent that time haggling with the insurance company and being threatened by a collection agency. On top of that, our son wasn't covered for the care he received right after being born, and we received a bill for the newborn check, none of which was covered by our insurance. This would never happen in Australia.

President Trump, you were right. We do have better health care here in Australia. Don't you think Americans deserve the same?

Marie Shieh, M.D., is an American physician who now works in Australia. She was born in Salt Lake City and raised in Kansas City.

SAMPLE LETTERS TO THE EDITOR:

Why $32 trillion over 10 years for single payer would be better than our current healthcare system [192 words]
Los Angeles Times, June 9, 2017

To the editor: Healthcare punditry has descended into mudslinging. The right, the left and the center are lost in the sea of regretful policy that has morally and fiscally bankrupted our healthcare system. ("Are Democratic and Republican healthcare proposals really equally 'extreme'?" Opinion, Sept. 19)

Physicians are demoralized and burdened by documentation as no other country requires, especially with electronic health records. When was the last time your family physician had the time to talk with you uninterrupted?

The only "beacon of hope" is with price and profit controls in a single, transparent system outside market forces. The health insurers have muddied the waters; Obamacare was not the answer. We must include physicians in the discussion for a healthcare public utility removed enough from government interference and politics.

The bean counters, including columnist Jonah Goldberg, are not physicians. The $32-trillion tab over 10 years he mentions does not give a complete picture. Extrapolating from a Lewin Group study a decade ago of the cost of providing universal coverage in California, hundreds of billions of dollars a year are lost nationally with our present system.

Yes, we can afford a single-payer system as a public utility.

- Jerome P. Helman, M.D., Venice

Townie right on AHCA provisions [258 words]
The Champaign News-Gazette, May 23, 2017

Kudos to Ryan Jackson (the Reluctant Townie) for his recent excellent article. "Rodney Davis voted for your death panel" by supporting the American Health Care Act that barely passed the House, 217-213. Let me add a few other points. Besides taking $880 billion out of Medicaid, it would take another $312 billion out of subsidies that help working families buy private coverage through the Affordable Care Act exchanges. Instead of helping people get care, this money would be diverted to give an $800 billion tax break to people with incomes over $200,000.

Davis's vote threatens to strip coverage from 57,300 people in our district.

But it doesn't end there. If the ACA is entirely or partially repealed, 413,700 individuals in the district with employer-sponsored sponsored health insurance are at risk of losing important consumer protections such as coverage of pre-existing conditions and the prohibition on annual and lifetime limits.

Also, 377,200 individuals in our district with health insurance covering preventive services like cancer screenings and flu shots without any copay, coinsurance or deductibles stand to lose their access if the Republican Congress eliminates ACA provisions requiring health insurers to cover important preventive services without cost-sharing.

Undeniably, the ACA is flawed. It left 28 million Americans uninsured and millions more with unaffordable premiums, deductibles and copayments. But the GOP plan would make things much worse. Instead of moving backward, we should move forward and go from the ACA to a Medicare for All plan like the one proposed by Rep. John Conyers (H.R. 676).

- Tom O'Rourke, Champaign

Why Medicare for All will work [96 words]
New York Times, September 13, 2017

To the Editor: Bravo, Senator Sanders! As a physician for 50 years and an activist with Physicians for a National Health Program, I am overjoyed to see this common-sense legislation. This morning, wearing a T-shirt with “Single-Payer Health Care for People Not for Profit” on the front, I was asked, “What is that?”

“Medicare for All,” I replied. “Oh, I’m for that” was the reply. “It’s so simple!”

Now comes the big struggle against those who profit from our current system. We must show our legislators that their jobs are in jeopardy if they fail to support this bill.

- Elizabeth Rosenthal, M.D., Larchmont, N.Y.

U.S. overlooks key to coverage [100 words]
The Columbus Dispatch, August 6, 2017

The Republicans were unable after seven years to find a market-based health-care solution. In health care, the markets and business are not the answer; markets and business are the problem. We are the only advanced nation in the entire world that hasn’t digested this fact, and thus we spend twice as much for poorer patient outcomes. We need single-payer, improved “Medicare for All.” Let us reject the callousness of the market and of state Rep. Mike Duffey, R-Worthington, who said, while proposing yanking health insurance from so many of us: “The reality is we will all die at some point.”

- Dr. Brad Cotton, Circleville

SAMPLE PRESS RELEASE:

Hundreds of doctors to march in Chicago for single-payer health care

Health care advocates keep pressure on Congress as Medicare for All gains record support

FOR IMMEDIATE RELEASE: April 29, 2017

Contacts:
Clare Fauke, communications specialist, PNHP, clare@pnhp.org, 312-782-6006; or
Pastor Emma Lozano, Lincoln United Methodist Church, Emma@somosunpueblo.com, 773-671-1798

WHAT: "Health Care as a Human Right" march and rally
WHEN: Saturday, April 29, 5:00 p.m. to 6:30 p.m.
WHERE: March begins at Malcolm X College, 1900 West Jackson Blvd. at 5:00 p.m, continues south on Damen. Rally at the Louis Pasteur Monument (in front of Old Cook County Hospital), 1900 West Harrison at 5:30 p.m.
WHO: Approximately 200-300 health care professionals wearing white coats

This Saturday, hundreds of doctors and other health care providers will join community members to demand an end to our nation's fragmented, for-profit health system. Wearing their white coats, marchers will call for congressional leaders to enact H.R. 676, The Expanded and Improved Medicare for All Act.

"Even under the Affordable Care Act, millions of Americans remain uninsured, and those with insurance have high co-pays and deductibles that deter them from seeking care," said Dr. David Ansell, Senior Vice President and Associate Provost for Community Health Equity at Rush University Medical Center and a member of Physicians for a National Health Program. "Now is the time to replace the Affordable Care Act with real health care reform—Medicare for All—for our patients, family members, and neighbors."

Momentum towards a national health program is unprecedented. While congressional Republicans try to strip the Affordable Care Act of its most basic provisions, the Medicare for all bill now claims support from a majority of congressional Democrats with 104 co-sponsors.

"Health care is a human right, not a commodity to be bought and sold," said Pastor Emma Lozano of the Lincoln United Methodist Church. "Families should not have to choose between putting food on the table and taking their kids to the doctor."

Other speakers include:

- Nahiris M. Bahamón, M.D., resident in pediatrics at University of Chicago and a board adviser for Physicians for a National Health Program
- Paul Pierre, M.D., Partners in Health
- Linda Rae Murray, M.D., M.P.H., former Chief Medical Officer, Cook County Public Health Department
- Claudia Fegan, M.D., executive medical officer for the Cook County Health and Hospital System and chief medical officer at John H. Stroger Jr. Hospital of Cook County; national coordinator, Physicians for a National Health Program.

Physicians for a National Health Program (www.pnhp.org) is a nonprofit research and educational organization of more than 21,000 doctors who support a single-payer national health program.