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HEADLINE: Hopkins CEO hopes candidates tuned in;
"24/7": The prime-time miniseries brought needed attention to health care issues beyond Medicare.

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BODY:

For a physician who has spent his entire professional life in the staid environs of academic medical centers, it's been a bit of a jolt to read columns by television critics comparing a series about my institution to "Survivor" and "Big Brother."

Last year, when ABC-TV news executives persuaded me to allow them extraordinary access to film "Hopkins 24/7," a six-part, prime-time series, I hadn't even heard of the other reality shows that would make Johns Hopkins part of this summer's popular genre. But I was disturbed enough by the unreal, irrational, through-the-looking-glass world of health care in this country that I believed some good must come from allowing the public an unvarnished view of the problems constantly confronting our patients and our staff, from struggling with HMOs to patching up the victims of inner-city drug wars.

Other than to insist on ironclad protection for patient privacy, Hopkins had no control over what ABC chose to focus on and no right of review. Fortunately or unfortunately, the problems we confront were so obvious to the producers that they couldn't overlook them. My hope is that those advising the candidates on their health care policies also were watching. It might help them to realize that their focus on Medicare and prescription benefits for the elderly is just a fix around the edges of the health care crisis -- not the entire answer.

For instance, the series offers a candid view of a young patient in pain, her family, physicians and clerks struggling to determine what tests her insurance will cover. Can she have a CT scan at Hopkins, or will she need to go across town or return to her home state? The producers told us they saw this scenario repeated over and over. They could hardly miss it, because the extent to which insurance companies have been inserted between the physician and the patient is unconscionable.

Let's agree that managed care organizations do a good job of providing preventive care -- immunizations, checkups, standardized diagnostic tests -- to the young and healthy. But when it comes to dealing with any serious medical problem, we must get them out of the decision-making process. Their interference doesn't improve care, and it

doesn't save money. One major HMO has recognized this and dropped its "utilization reviewers." With all the hoops and justifications required by most other managed-care organizations, we say that "it takes a village" of back-office people to deal with each patient. At least 30 percent of each health care dollar is spent on administrative costs, not on actual care.

A whole series of steps might remedy this situation: If the government covered the costs of catastrophic care for all ages, then managed care organizations would have some protection from loss and thus less reason to try to limit their cash flow through harassing practices. (At the very least, there should be agreement on standardized forms, rather than the proliferation of different formats demanded by each company that creates a paperwork nightmare and inevitable errors.)

And just as there should be catastrophic coverage, the government should provide a broader safety net for basic coverage that addresses the issue of the 45 million uninsured in this country. Without addressing this issue, we're just cost shifting and putting off the inevitable day when critically ill people are brought to our emergency rooms, at the point when they can't be turned away.

Ironically, there's already another group of patients for whom we "providers" do not need to obtain advance permission from insurers before initiating treatment: the critically injured. The camera's eye captured the gruesome results of Baltimore's drug wars. During the past year, close to 400 shooting victims were brought to our emergency department. What a waste!

Our new, energetic, young mayor has been pleading for more drug treatment money. As the situation stands, fee for service drug treatment programs could handle more addicts, but those most in need rarely have the insurance coverage or the money to pay. The few free programs have long waiting lists, so at the moment when addicts are ready to kick the habit, they're often rebuffed.

Social workers in our emergency room spend hours on the phone trying, unsuccessfully, to find placements for these people. Meanwhile, our prisons have become warehouses for addicts who often are released, still addicted, to resume a life of crime and to end up in our ER, shot up or with AIDS contracted through an IV drug habit.

What's wrong with this picture? If a fraction of the money that goes into treating hundreds of critically wounded shooting victims and thousands of AIDS patients went into free, aggressive treatment programs, society and the health of our cities would be well-served.

Perhaps above all, I think the television series demonstrates our indefatigable advocacy on behalf of our patients, whether we're dealing with current treatments or developing new ones. I hope the candidates and their advisers understand that we in the medical profession would like to work with them in developing the cure for what ails this nation's systemic health care problems, as well.

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