PEOPLE MEDICINE
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A Frugal Physician

prescribes

Common Sense and Enthusiasm

by

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Afterword and Appendices
Dedicated to the Spirit of HPB


“The progressive thinking of one era is the common sense of the next.”
Matthew Arnold

“Every great and commanding movement in the annals of the world is the triumph of enthusiasm.”
Ralph Waldo Emerson

“First, do no harm.”
Hippocrates
Foreword

The idea for this book arose after a brief encounter at the grocery store. I ran into Dwight Thompson. Dwight is our local Physician Assistant, a kind-hearted man with many years in rural practice. He is also a thinker.

Once in a while we run into each other and compare notes for a few moments. That day, we focused on the small town hospital’s recent loss of its only full-time, long-term physicians - a husband and wife team. As they were heading back to their home state of Michigan, the citizenry and hospital staff were wondering and worrying about the future of the hospital, clinic and nursing home.

Dwight said something like, “Things sure have changed in our time. It’s harder and harder to keep a small town hospital running. Costs are so high for our facility and for our patients.”

The conversation turned to what health care providers do and do not know about costs of tests and treatments they recommend. Dwight admitted he wasn’t well informed on the former. We both related that we had NEVER had classes in our training on medical care costs. It just wasn’t considered necessary.

However, technology is coming to the rescue - to a degree. Dwight pulled out his Blackberry and ran a program which showed the costs of common prescription drugs. He quickly pointed out one which was priced at ten dollars a pill. That was hardly top price. My teeth dropped, not having purchased any kind of medication in decades. “How does anyone afford it?”

Obviously, many people can’t afford modern medicine which has prompted politicians and legislators to try to “fix” the medical care system. But, the first question also begets others like:

Will reformed medicine be more affordable than what we have?
Will the new version just be more of the present system?
Is our current system as good as generally thought?
Are the costs of medical intervention equal to the benefits?
What about the side effects, accidents, negligence, malpractice?
What about alternatives, prevention, traditional practices?
Is it possible to go beyond the current medical paradigm?

This book evolved from the angle of frugality, conservation and common sense. But, it has gathered a life of its own and has grown to address the whole of the modern medical system.

Though a small volume, PEOPLE MEDICINE considers not just saving medical money but also the dogmas of medical training, the reliance on tests and technology, the religion of science, the “bigger is better” concept, competence vs. care, and more. The book does not just poke and prod on problems and shortcomings, but suggests real life possibilities for change and improvement.

If you read between the lines, A Frugal Physician can help YOU conserve resources, ask the right questions, gain perspective, learn about health and disease, and better understand the system in which you place your body and your hopes. It can also teach you how to recognize the caring, conscious people you need when you are ill or injured.

**Note I:** This book is meant to bring information, ideas, and maybe a little inspiration to the table regarding modern medicine and healing. To accomplish that aim, it is necessary to look at the defects, errors, and problems in the present system. COMMON SENSE helps out here.

This process leads us to consider BETTER WAYS, things about which we can show ENTHUSIASM. But at the same time, the author wants the reader to remember that over all, physicians and nurses have been and are hard working, caring and unstinting in their efforts to aid and comfort their fellow beings. Their sincerity and desire to be of service are credits to the human race. They have taken on the challenges of disease and pain, trauma and injury and made sacrifices for the betterment of their brothers and sisters. They deserve honor and thanks for bringing us this far.

Yet, medicine and its practitioners have not kept pace with the illnesses and problems of the times as well as the world of deep and growing knowledge which surrounds us. We continue to fight old diseases with stale ideas and limited perspectives. It is time to make substantial changes in medical practice which fit with the people and the era.
Note II: One reviewer has called a number of the thoughts and themes in the book extreme. There is truth to the suggestion. Let the reader beware, but also consider the real possibility that modern medicine may be itself the greater extreme.

Note III: Most medical professors and mentors retain their real names in the book. Innocent friends as well as the potentially “guilty” who may take offense have been given pseudonyms.

Note IV: “All medicine is anecdotal.” Since every person is unique, every illness and injury is as well. Statistics do not mean much in individual situations. But stories may pass on real value to those who are open to them. Statistics are not known for their healing ability, but a well told tale may revive or rejuvenate, invigorate or inspire.

Note V: Here are some thoughts on the word Frugal. It may be a more inclusive word than the reader has imagined. Like many words, Frugal (derived from the Latin frugalis for virtuous, after frux for fruit) has lots of meanings. We can use the word as a standard and guidepost, considering it in its best light to mean:

- careful
- caring
- conserving
- disciplined
- economical
- efficient
- mature
- parsimonious
- practical
- preserving
- provident
- prudent
- sage
- sensible
- saving
- sparing
- thrifty
- unwasteful
- wary
- wise
PART I: COMMON SENSE

Common Sense and Enthusiasm

Shortly after completing the first clinical rotation of my junior year in medical school, I received an “invitation” to meet with Senior Physician Dr. Walter Kirkendall, the Chief of Internal Medicine for the Hermann Hospital and the whole medical school (University of Texas Medical School at Houston). I had no idea what prompted the summons, but quickly found out once I stopped into his office.

Kirkendall was an aging internist, a big guy in a long white coat with professorial glasses sliding down over his nose. He was a looming authority figure and I was just a tyro. Still, he was neither welcoming nor unkind. Just matter of fact. He didn’t ask me to sit down. He simply got to the point. “Your evaluation for your first rotation on Medicine was not very good. It concludes, ‘Student lacks common sense and enthusiasm.’ Let’s see that you do better in this next round. I don’t want to hear anything about a repeat performance.”

Short and sweet. Well, not really sweet. Not harsh either. Dr. Kirkendall added something to the effect that the next evaluation would have to show improvement - or else.

The first two years of medical school were (and still are) largely classroom work, sitting for hours listening to generally boring, uninspired lectures and speakers. (If I had to do it over again, I would skip practically all classes, read the texts which I would anyway, and find real life experiences to fill the time I “should” be in the classroom.)

A common refrain in the Texas Medical Center and other points of medical training was “Them that can do, do. Them that can’t do, teach.” I couldn’t object much. Actually, I came to the conclusion that the quality of teaching I sat through for almost two decades of my life had gotten worse instead of better as my education progressed to “higher” levels.

An anecdote about a notorious professor at our neighboring school,
Baylor College of Medicine, circulated freely if not accurately. Most certainly it carried savory grains of truth. Apparently, the medical man directed a course to a large group (200+) in an amphitheater-style auditorium. (I was in one of the first classes of UTMSH and our group of 52 had the “luck” to be taught for two years in cramped makeshift classrooms on the 11th and 12th floor of Center Pavilion Hospital, then on the edge of Texas Medical Center.) While his lectures were poorly received, the instructor didn’t pay heed. His talks droned on and on. But, what was a student to do?

Medical people - even students - are rarely spontaneous or innovative, but one student took it upon himself to make a statement for the whole class. His friends helped him move a couch into the auditorium prior to a lecture session. They placed it strategically at the base of the amphitheater directly in front of the long counter behind which lecturers were wont to speak and scribble on the equally long blackboards covering the rear wall.

That day as the professor’s drone became oppressive, the brave young student quietly left his seat and stretched out on the couch. He was soon asleep. The professor either didn’t notice or didn’t care. Surely, the students must have found it difficult to keep from bursting out in laughter.

I can count on one hand the number of interesting professors and classes we had in those first two years - and still have fingers left over. Only one instructor comes to mind at the present moment. That is Dr. Guillermo Nottebohm. The Argentine firecracker was a nephrologist (kidney specialist) who taught classes on internal medicine. He was dynamic, devoted to his work and specialty. He moved around, tried to engage the people in the seats, and told pertinent or at least provocative stories. While he didn’t have “new” information for us, he presented his classes with some energy and excitement.

I recall his recurring pronouncement given out when students said they hadn’t gotten their reading or assignment done. Spoken with his spicy Spanish accent, he said, “My young man, you really have no excuse. There is no requirement for medical students to get sleep. So, you certainly had time to get this work done.”
Dr. Nottebohm and a bare few others helped us survive those grueling hours in our tiny, stuffy classroom. Fortunately even in the first med school years, we did get away for a few hours each week for one kind of practicum or another. When we reached the third year, everyone was quite relieved. Our butt-numbing classroom hours were slashed to a minimum.

We then spent practically all our time on one ward/service or another - six weeks at a stint. The ward team usually consisted of an attending physician who was the titular head of the group and appeared at his/her own discretion. Some did daily, others on occasion. Generally, s/he handed responsibilities over to a resident physician and an intern. Medical students pulled up the rear and took directions and orders from everyone. We did physical exams and procedures, chased test results, made regular rounds checking on patients, attended our mentors’ needs and whims, acted as go-betweens, and did whatever other gopher work was delegated to us.

My first rotation was on the Cancer Ward at the Hermann (University) Hospital. It was a sad and depressing place for patients and workers alike. The prognosis for most patients was less than hopeful. When my “cancer rounds” were over, I thought I had done the work and followed the program. But, I learned otherwise from Dr. Kirkendall. I had opened my mouth one too many times.

Dr. John Rogers, the Medical Resident on the Cancer Ward, was tightly wound and equally bound to the medical orthodoxy. He had obviously not liked my pointed questions, especially when I showed I was unconvinced as to the value of some of the treatments - antibiotics and steroids, steroids and antibiotics - which we doled out so frequently and freely.

On one occasion, I remember Rogers calling me a “therapeutic nihilist.” Suggesting that I wasn’t enthusiastic about any medical methods. He wasn’t far from the truth.

By that time, I had developed a questioning eye and skeptical opinion about many things. I also had studied enough on my own about other schools of medicine, traditions and alternatives to object, at least inwardly, to many teachings we were expected to accept at face
value. Supplemented by my several years of experience as medical corpsman, Xray assistant, vocational nurse, and medical technologist, I had a broad knowledge base larger than most medical students and as wide as many resident physicians.

I found that the modern medical guild, probably like older ones, does not appreciate alternative thinking. When I was in Uncle Sam's Army, we were told, “There's the right way, the wrong way, and the Army way.” There's a Medical way, as well.

Chief Resident Rogers also took it quite personally when patients died, on one occasion painfully and blatantly blaming the nurses. Death in the medical system is too often seen as a failure. And with failure, someone needs to take the blame.

But, really! People die, like cancer patients on cancer wards.

Nonetheless, MY basic problem was “lack of common sense and enthusiasm.” I admit that I most surely must have frowned inwardly as well as questioned more than was “right for a newbie.” I didn’t have the common sense to keep my mouth shut when I couldn't be clearly enthusiastic about standard methods.

I tried to button my lip more the second time around than the first. (Not an easy task.) But, that second rotation went much better - or, again, so I thought - at St. Joseph's Hospital which was located in downtown Houston away from the Texas Medical Center. Dr. Jim Peterson, the head resident, was decidedly laid back. He wasn’t out to shine, just get the job done, take care of people, and move along the medical corridor. The number two man was an OB-GYN intern who tried to lighten the load with laughter. Further, we were working on a general medical ward. Death was not the constant daily threat as it had been at the Hermann cancer ward.

I did my work, followed the protocols, and made no waves regarding patient care. So, I was not entirely surprised that there was no further word from Dr. Kirkendall. However, some weeks after finishing that rotation, my medical student partner at St. Joseph's let me know, “The word is that they lost the evaluations Peterson wrote for us!” Maybe that was for the good. I will never know.

I do know that, then and more so now, common sense and
enthusiasm are essential to a well-rounded life as well as for health and healing. Despite the seeming opposition of the terms, the two might fit nicely on a crest designed for a Frugal Physician.

I have to stop here because I can’t help but think that we humans are prone to project our shortcomings on others. I was accused of lacking common sense and enthusiasm. I have since admitted the truth of the accusation. I wonder if medicine and its practitioners can stand up to that accusation as well. My experiences of Kirkendall and Rogers suggested them to be neither particularly common sensical nor enthusiastic.

Much of modern living seems to avoid common sense: “Just follow the regular program.” Express your enthusiasm for something extraordinary: “Hold your horses.” Object to the status quo: “You are upsetting peace and decorum.”

The same ethos seems to hold sway in the corridors of medical institutions most everywhere. Yet, medicine and modernity must find room again for common sense and enthusiasm. I suggest that they are two of the keys which will open the gates to further layers of growth and understanding in the coming era.

COMMON SENSE is a stabilizing force necessary for all of us, whatever our pursuits and interests. “Common problems call for common sense.” Common sense suggests mental balance, the gift of discrimination, and rational perspective. It points to the HEAD - a clear one.

Simple approaches and measures should suffice to deal with most medical problems. They have in times past, in less developed parts of the world, and even now with many who don’t readily go along with the medical orthodoxy.

Medicine seems to respond: “Things are not so simple as you might think. We have developed protocols and practices which have proven generally effective over the years. We apply our highly technical and tested knowledge toward the betterment of our patients and society.”

Medicine and physicians wish us to believe their works to be arcane and understandable to only the trained and certified. Medicine has long
been mystified so as to empower physicians and make patients and public dependent. The whole of life has been medicalized in the words of Ivan Illich (*Medical Nemesis*). Wise Physicians know and act otherwise to share knowledge, promote health and level the field.

ENTHUSIASM, coming from the Greek *en theos* and meaning in God, inspired by God – points to energies of the HEART. To the author, enthusiasm hints at being on fire, devoted to an unselfish, universal cause. Enthusiasm opens us to the deeper parts of our humanity, world, and life.

Medicine replies: “Our work is to tend and repair the human body. We know nothing of the soul or God. That is outside of our element. If a patient needs God, call the chaplain.”

Despite such objections, the forces of common sense and enthusiasm can help expand the dimensions of modern medical care beyond its present limited confines. One bringing down-to-earth focus and the other reaching for everpresent hidden possibilities. “Feet on the ground and head in the heavens.”

We are all so built - more or less. Why can’t the future medicine grow in that direction? One Frugal Physician believes so. “Once a physician, always a physician.”

Maybe Drs. Rogers and Kirkendall did me (us) a real favor by helping to point out these fundamental forces which can be used to direct our steps in the ways of A Frugal Physician.

In the following pages, we will draw on common sense to look at the present state of medicine. Enthusiasm will arise later as we consider brighter and better ways which can lead all of us from medicine to healing.

The epithet “frugal physician” is an oxymoron just as in a similar vein, common sense and enthusiasm make for a combination of near opposites. However, both can make for useful pairs.

Here are a few other medical oxymorons, most of which we will consider as we go along:
Putting Frugal and Physician together is clearly unusual and uncommon. A quick search at Google gives a paltry string of 200 citations out of billions of web pages. “Frugal physician” references mostly point to ways for physicians to save money and resources in their offices or how to adjust their lifestyles at home. A large share of results are given for Frugal Physician Medical Supplies, a name brand. There is nary a word about medical people helping their patients to save money.

In the modern world, the practice of medicine very often mandates substantial costs. Even to walk into a medical office necessitates leaving several large bills on the counter or writing a good sized check.

“Physicians are not taught to save money. They are taught to save lives.” I just made that one up, but it seems a relative medical truism in the common era. (Saving lives is another oxymoron we will survey later.)

Medical people need to know that financial health and physical health go hand in hand. One reflects the other very commonly and is dependent on the other more than is often apparent. That is a basic understanding for a Frugal Physician.

With expensive tests and technology, pills and procedures taking over larger and larger swaths of medicine, parsimony in health care is almost unknown. It was known and common in the past. The time is surely opportune for a return to rational and wise medical care. Such may become infectious and break out in the rest of society.

Common sense and enthusiasm may help us achieve such a desirable destination. Frugal Physicians must help bring that into being. Money will be saved, resources conserved, and waste reduced. At the same time, human beings will be enabled to relate to each other more directly and wholesomely. Health and healing will rise like the phoenix out of the old and decrepit medical model.
Dead or Alive?

Common sense is surely still alive. Certainly, the common folk still have some common sense. Still, it’s just not as COMMON as it once was and harder to find in some places. Many forces in modern life make it more and more difficult to live simply, wisely, and economically.

In his 1995 book *The Death of Common Sense*, Philip K. Howard explains how our modern legalistic way of looking at things twists us around and makes common sense much less common. I heard New York City lawyer Howard on the radio a few years ago and was duly impressed with his message. The sixteen years since he wrote his book haven’t improved the general state of common sense in the world and more particularly in our part of it.

Subtitling his book *How Law is Suffocating America*, Howard says that laws and lawyers and legislators are making it very hard for people to live normal lives. Businesses and consumers seem to have the law hanging over their heads at most every turn. “You better not do that or you might get sued.” “You’ll get into trouble with the government if you don’t do this.”

The threat of litigation or government intervention is so prevalent that it affects almost every area of our lives. It makes things more expensive because of insurance, police, lawyers, etc. and makes us behave like we are paranoid. And our paranoia continues to grow, especially now with all the hysteria related to terrorists and the War on Terrorism.

One of the arresting stories Mr. Howard told over the radio was about a woman who was shopping in a furniture store when she tripped and broke her ankle. Claiming that the store was at fault, the woman went to court and got a judgment against the business for $79,000. On the surface, the judgment doesn’t sound too unusual or totally out of line. But, the kicker was that the woman had tripped over her own child who was crawling on the floor of the store. Can you beat that?!

We might be able to beat it, after all. There is a site on the Internet
which has been giving out Stella Awards to “honor” such kinds of events. The Awards were named after the woman (Stella Liebeck) who received a $2.9 million settlement from McDonald’s after Stella dropped a cup of hot coffee in her own lap. (Visit stellaawards.com.)

Philip Howard suggests that rules have become a religion. Laws are replacing our humanity. Uniformity is king while diversity is becoming illegal. Bureaucrats rule by relying on codes, laws, and regulations. Our government of laws works against us. Lawyers spend much of their time (and clients’ money) involved in adversarial legalisms. Lawsuits are rampant. Thought and judgment have been banished so that we fear government authority.

Most all of these points have bearing on the practice of medicine in our time. Let’s take a quick look at some of them.

“Rules have become a religion.” All kinds of rules circumscribe medical practice: Laws set down by the government through programs such as Medicare, Medicaid and Social Security; guidelines from insurance companies; standards set by the American Medical Association and the American Hospital Association; and so on. Hospital and clinic administrators literally have REAMS of rules to follow.

Medics aim at Quality Care but often end up meeting guidelines and keeping the closet clean for inspection. The medical situation is akin to standards set by the recent No Child Left Behind Law which create lowest common denominator kinds of schools. Such laws, although well intended, do in fact become “religious dogma” which practitioners, clinics and hospitals must follow. Else they be excommunicated.

I am reminded of a report sent out by my medical school following our 20th year reunion. The main theme going through comments of my old classmates was too much paperwork, too many rules, too much government intervention. Several seasoned physicians hinted at wanting to find another profession.

“Laws are replacing our humanity.” In the medical setting, paper work and protocols become more important these days than direct care
and timely attention to human concerns for the patient and often for workers in the field. Throughout the medical chain of command, paperwork rules.

There is only so much time in the day to meet all demands. So, mandated rules and attendant forms take precedence. Care is too often determined by squiggles on paper rather than effects in patients’ lives.

I remember talking not long ago to an ER doc who complained about paperwork and the “cut and paste” process which had then become the pattern for completing required examination forms. In my own case when I was an Army flight surgeon, I was mandated to do rectal exams with every annual flight physical. When paperwork was returned because I hadn’t performed the test - thinking it intrusive and unnecessary, I lied and checked the WNL (within normal limits) box. The system accepted my lies.

Quality Assurance has become a numbers game. Hospitals distribute surveys for patients to rate their care according to a Numeric Scale. That seems like another oxymoron to me.

“Let’s make Quality Care quantitative,” some number cruncher decided. Administrators bought it. Workers use it. People accept it. But, something is surely awry in the process.

“Uniformity is king while diversity is becoming illegal.” Well, it has been a long time since the medical profession had room for diversity. Pills and surgery or surgery and pills are the options. If all else fails, the psychiatrist can be consulted.

Innovation is relatively unknown because treatment for labeled and diagnosed diseases are prescribed and alternatives are proscribed. “If you want to use non-standard methods, go back to chiropractic school.”

“Bureaucrats rule by relying on codes, laws, and regulations.” A common complaint is that bureaucrats of one kind or another and insurance examiners are dictating medical care. There is a certain amount of truth to the statement.

How would patients fare if such influences were not active? Would
medical practice really be much different? Most physicians themselves are much more like technicians and bureaucrats than they might ever realize or admit. They regularly follow the same old patterns, like we all do to one degree or another.

Such observation brings up the adage that “Insanity is doing the same thing over and over and expecting a different result.” Too often these days, we are allowed no choice. So, the pattern just continues.

“Our government of laws works against us.” Attorney Howard’s point is that modern laws and rules make “one size fit all.” That practice worked for a time. But not forever simply because one size does not fit all.

Times and people have changed. Clearly, our systems have not kept pace.

I am reminded of how patients are so commonly corralled into cancer treatment protocols in which they have to follow their program to the letter. Patients are then more manipulated than really cared for. A whole book surely could be written about patient experiences revolving around destructive cancer therapy laid out in lockstep series of X number of treatments over so many days or weeks so that statistical studies can be done. Their disease and the test program overrule the needs of the patients. How sad, but how regularly accepted.

“Lawyers spend much of their time (and clients’ money) involved in adversarial legalisms.” This is the “letter of the law” mentality over the “spirit of the law.”

Is your physician caring for you or instead battling some diagnosis, disease, label or phantom? Is s/he reading you or just studying the textbook?

How much of your physician’s time is spent with you as opposed to your paperwork and tests? Is s/he dealing with numbers and letters or your spirit?

“Lawsuits are rampant.” Well, we don’t have to go far with this one. Malpractice lawsuits are more and more common. Part of this state of
affairs is because lawyers are eager to sue. That’s how they make money.

The USA has more lawyers than any other country in the whole world. Not surprising, really. We have one lawyer for every 265 of our citizens. Compare that to the United Kingdom which has one for every 1400 people.

Another part of the problem develops when physicians don’t take adequate time with their patients, treat them as another case, and forget that they are dealing with human beings. They set themselves up for errors and problems and lawsuits. Fortunate for them it is that thousands of incidents of error and negligence are overlooked because many patients are quick to forgive even though they take the hit.

But, that is surely changing. Litigiousness is a contagious disease growing with the years. And it is surely catching more and more of the population.

I have often reflected that a lawsuit is one of the few ways for someone in the lower/middle class to take a step up. We used to have opportunities to capture land and space and make our way up the economic ladder. Those options are very limited in the modern world. In the present day, lawsuits, lotteries, and sweepstakes have taken their place.

“Thought and judgment have been banished so that we fear government authority.” The key part of this statement revolves around “thought and judgment” which suggests a re-statement of some of the earlier points.

In recent times, I have said much the same but with other less kind words. I look around and think, “People have lost guts and imagination.” Sad to say, in the western world, we have become nations of sheep.

We are sheep-like not simply because we aren’t capable of more, but largely because our laws and systems have become crystallized and diseased. We continue to prop them up, reinforce them, prevent them from disintegrating and being replaced by new and vital ones. We believe in our staid way of life and have trouble imagining any thing better, although it must be so.
Medicine, like law and government and many other institutions, must open to change. Else they are all doomed to fall apart due to obesity and constipation, short-sightedness and simple ineptitude. Common sense has been replaced by double talk, greed and waste.

Bottom line: The medical system is not alone in its discomfort and ills. Laws and paperwork rule. Doctors and nurses, clinics and hospitals really want to look out for your better health interests. But like the whole country, including the legal system and government, medicine is affected by a long standing and contagious paranoia.

“Better do more tests to CYA (Cover Your Ass),” is a common thought in the profession. Consciously or unconsciously held. CYA is not often voiced aloud, but physicians have it ringing in their ears or drumming on their shoulders. Physicians don’t want to miss anything - whether it is for your benefit or theirs - even though it might cost an arm and a leg to find. Yours!

Confronting this sad way of thinking and acting gets harder as the years advance. Common sense seems more and more remote.

Fortunately, it only takes a few to begin making change. A Frugal Physician, motivated by common sense and compassion, thinks first of his/her patients, rather than forms or legalisms. S/he works out of love, not out of fear.

Practicing Medicine

In his book, Philip Howard quotes Grant Gilmore of Yale Law Professor, who had the cheek to say, “The idea of law has been ridiculously oversold.” I follow his lead and suggest, “The idea of medicine has been ridiculously oversold.”

Actually, it is the practices rather than the professions which have been oversold. Both professions are needed and praiseworthy when rightly practiced. Both professions seem to have - as my mother might have said - gotten too big for their britches. Making unfounded claims,
promoting dubious services, leading patients and clients to believe that they can deliver the undeliverable. Often preaching more than they really practice.

Many factors including the several listed in the preceding chapter make it difficult for any physician to practice the ART, in whatever way s/he understands his/her calling. How does a doctor make art out of dogma and rules and legalisms? How does a physician create art out of science, especially since art, like business, nutrition, health, is scarcely given time or credence in medical training? Is s/he enabled to address patients’ real problems?

The author believes there should be a step beyond practicing medicine. Electricians, plumbers and other tradespeople go through defined stages of training and advancement, like apprentice and journeyman, to eventually become masters of their trades. That is not the case with physicians and lawyers, which should give patients and clients some clues.

Generations ago, young physicians apprenticed to older ones. That was in a much different world. Theoretically at least, mastering medicine may have been more possible in those times.

I probably never met a physician who has mastered medicine. Dr. Smythe (see Routine Tests) may have gotten close. The rest of us just practice/d it.

As opposed to common belief, physicians are far from erudite, wise, and all-knowing. For one thing, the trade that they ply is so much more complicated than that of an electrician and plumber. The breadth and depth of plumbing and electrical equipment, installation and repairs are relatively knowable.

Physicians work with living beings who are far more than their bodies which however are the intense focus of physician attention and work. (Does your physician treat you or your body?)

Since we still KNOW only a fraction of human potentials and physicians usually UNDERSTAND human problems only superficially, we may actually have NO Master Physicians. The best you will likely get is one who is caring, growing, learning, changing, willing to listen and explore your person, life situation, and challenges as well as his/her
own: A Frugal Physician.

The simple, straightforward fact is that physicians are accomplished at one level or another of Educated Guesswork. That’s right. When you go to most any practitioner (there is that word again), you are paying money for him/her to practice on you. No doubt, s/he has studied long and hard, made the grade passing requisite exams, fulfilled professional commitments and been licensed, certified and insured. But, passing tests and ordering tests are only the standard facets of medical practice. Patients are the reason for the practice of medicine as well as the point where variation, exceptions, and wonderment set in.

As you will be reminded in these pages many times, every patient is very different from the last. Superficially, a patient may appear to have the same condition or problem as the next. But in a larger sense, that is quite likely to be untrue. And, your physician needs to recognize and honor that.

You and I and all people are unique. Thus we, to a greater or lesser degree, present to clinic and hospital with unique problems and thus unique disease.

Most physicians just scratch the surface when dealing with their fellow human beings. Two hundred years ago, the French writer-philosopher Voltaire hit the nail on the head for his time and into the present, when he said, “Physicians prescribe drugs of which they know little for diseases of which they know less to patients of which they know absolutely nothing.”

In some respects, things have changed dramatically in the medical world from Voltaire’s 18th century. Outwardly, anyway. Physicians have vastly more training, knowledge, and equipment. Scrupulously clean and expensive offices and medical centers. Grand arrays of tests and treatments to choose from. The best that money and technology can provide. Your money.

But with a Big Picture view, we can see - if we have the eyes - that things really haven’t advanced in many important parts of medical practice. Let’s pick Mr. Voltaire’s statement apart.

“Physicians prescribe drugs of which they know little . . .”
Medics have dozens, really hundreds and thousands, more drugs to prescribe than in Voltaire’s time. But, pharmaceuticals are expensive, over prescribed, and fraught with adverse reactions and safety concerns.

“But, they know a lot about them?” Yes and No, mostly No. How could your physician really know that much about even a tiny percentage of the available repertory? Or for that matter, know one single medication well unless s/he took it personally for an extended period of time? Or worked with many patients who reported to him/her regularly and faithfully about its internal effects? That is pretty rare. Actually, the physician probably wouldn’t like hearing all the details if the patient could verbalize them.

Pharmaceutical companies understand a lot about the drugs they manufacture. But, just knowing the science (pharmacology) of a medication tells very little about any single patient’s experience with it. Drug makers are scientists not physicians, and surely not patients. I don’t know of any patient who ever started a drug company to make his/her own medicine. Do you?

Your physician “tries” medications on his/her patients based on teachings in medical school (long past and largely forgotten), the latest rap from visiting pharmaceutical reps, and the hype in the medical media. Sometimes, even from patients asking about such things as the Purple Pill. A tiny few physicians do individual study or go for continuing education on medications. But too often, such latter events turn out to be drug company paid vacations, promotions of pills and equipment, audiovisual slide extravaganzas, and/or medico-political rallies.

Consider now the dozens, hundreds or thousands of drugs available for physician “trials” and use. It would be quite an accomplishment for him/her to REALLY KNOW much about even a small number of those meds.

Oftentimes, the drug makers don’t even really know as much as they should about the pills that they produce and push. The reader might pick up a Physicians’ Desk Reference some day and peruse the technical sections regarding common drugs.

Actually, the PDR is hard to pick up these days. It used to be a few
hundred pages long (400+ in 1950), but now it is contained in two bulky volumes, tight print, thin paper, 3000 pages, weighing more than 8 pounds. The PDR is the modern drug bible, consulted by practically all physicians, and sponsored (paid) by the drug companies which fill its print with information on well over 4000 pharmaceuticals.

An intent reader of the PDR will discover that the mechanisms of the supposed actions of most drugs are often incompletely understood. Even aspirin’s effects are still not fully known. “More research into these therapeutic mechanisms are needed and under active consideration,” is a typical conclusion for the data on any particular drug.

“Physicians prescribe . . . for diseases of which they know less.”

You think, “At least, they understand my disease?”

On some occasions, they do. In most situations and with most conditions, they don’t. (See In the Name of . . .)

Like drugs, there are more diseases in the modern era. Or at least, there seem to be. Because physicians and scientists have been discovering and identifying an endless list of syndromes, diseases, symptom-complexes, ills and ailments, affections, conditions, contagions, disorders, maladies, pathoses. And, that ain’t all!

Hundreds of newly cataloged diseases seem to have called the growing number of medical specialties into being. Maybe it is the other way around. The growing number of specialists need more diseases to treat. Note: To discover a “new” disease is a real honor. It might be appropriate to interject here that specialties and specialization are not peculiar to medicine but to our whole modern society. Generalists like general practitioners are passe in the USA. I am told that GPs are still fairly common in the United Kingdom. There are certainly benefits from specialization, but just as certainly malign effects. Specialists lose track of The Big Picture and often don’t even have a clue that one exists. People and their ills are really Big Picture issues.

Interestingly, there are few medical specialties devoted to specific diseases. In part because there are few specific diseases. We do have oncologists (specialists in cancer, of which there are dozens of types reminding us how little the disease is understood), rheumatologists, and infectious disease doctors. Rheumatology itself is a very non-specific
specialty (another oxymoron) that tries to fill some gaps in medicine. You might be interested to consider the wide range of ills which rheumatology attempts to address.

Specialists generally work on PARTS of the BODY. Eye doctor, ENT, dentist, foot doctor, abdominal surgeon, chest cutter, psychiatrist (head man). Then, there are specialists for age groups: pediatricians and geriatricians. Women have their own specialty: gynecology.

You might think that the body has been covered by now with all these specialties and subspecialties. Not quite. The writer figures more specialties are on the way. One day, we may well have right eye doctors and left eye doctors. What do you think?

The author had thought the last idea was original. But while editing this book, he ran across the following quote in his extracurricular reading: “[Ancient Egyptians] had put everything to such a degree of specialization that we must conclude they had many centuries of civilization. There was a specialist for one eye and a specialist for the other, a specialist for the eyebrow, and so on. In my poor humble opinion, we are the Egyptians.” (From a speech given by William Q. Judge in 1892, published in Echoes of the Orient, p. 524)

The simple fact that physicians have formed hundreds of specialties and categorized thousands of diseases clearly suggests that they are often “chasing ghosts.”

“Physicians prescribe . . . to patients of which they know absolutely nothing.”

Here is the most important part of the equation. We can address that concern very directly by asking you a few questions: How much does your physician or surgeon really know about you? How much can s/he learn in ten or fifteen minutes’ time spent with you in a crowded schedule in a stuffy treatment room?

On the other hand, how much are you even willing to tell him? How able are you to put into words what is really going on in your body and in your life? What would it take for your doctor to fully interpret your experience, understand your discomfort, and know what is going on in your body, mind, life?

Well then, nobody’s perfect. Neither physicians nor patients.
Physicians need patients and patients need physicians, but often for more than the usual suspect reasons. Thus, we continue on. Old patterns, same results.

When asked about my old profession, I used to tell acquaintances (but rarely patients): “I practice medicine.” Interestingly, many people didn’t get the idea at all. “Does that mean you’re a doctor?” They had never heard that physicians practice medicine. Others got the meaning because of the inflection I put into the word practice.

If I told a patient, he might take it the wrong way and think maybe he had put himself in questionable hands. “I’m paying you real money. I want real medicine. Aren’t you a real doctor not somebody who is just practicing?”

Sharing the idea on occasion with a friend was less problematic.

Doctors in fact practice medicine just like attorneys practice law. The work of both professions is very subjective. Medicine even more so than law.

“Standard medical practice” has many traditions, protocols and guidelines. Tests and procedures help point practitioners toward supposed workable diagnoses and labels. There are even algorithms (standardized steps used to solve problems) which can assist novices and assistants in following lines of investigation.

But in dealing with any individual patient, there is a huge spectrum of possibilities and questions to consider. Every body is different. Every person is also different. Likewise, every physician is different. A wise modern physician knows that. Does yours?

This is where the ART of medicine comes in. On more than a few occasions, I have thought it might be provocative and revealing for a TEST to be done of medicine and its practitioners. By taking a number of real patients with undiagnosed conditions and sending them to ten different physicians. Then comparing patterns of practice and treatments given by the providers. The survey being done with video would make for an interesting movie.

This sort of thing is rarely done in medicine. (Almost all medical exams, even board certifications, are done by written tests.) The exceptions seem to be in the context of training. Or when a physician is
suspected of engaging in non-standard, questionable medical practices. The profession takes it on faith that Regular Physicians are “following standard practice” unless they hear otherwise from patients or peers.

I had my own small taste of such a video experience during my medical school training - third year. In one of our Family Practice programs, each of us was assigned a new patient to interview before a videotaping camera. The interview was then discussed in the presence of other students and a supervising physician. Each student was further expected to follow his/her patient over the course of the year.

Joyce was selected as my patient. I first met her only moments before the video interview. We sat rather uncomfortably before the camera as I conducted one of my first clinic interviews. Joyce and I had a wide-ranging conversation that allowed me to bring out things about her which had not been previously discovered.

Joyce was a thinnish, black woman in her late thirties who came to the Hospital Clinic in downtown Houston that day because of left-sided chest and arm pain. She had, just moments before, consulted with a Family Practice resident. That physician, who was already trained in psychiatry, had conducted a standard history and examination of the patient. He then ordered blood tests and a heart tracing. The procedures revealed “no significant abnormality.” All that was and is quite standard procedure, but didn’t do Joyce much good. It likely cost her more money than she could afford.

During our interview, I learned that Joyce had grown up in Louisiana and had moved to Houston some years ago with her husband and daughter. She was recently separated from him and didn’t know his whereabouts. Her only daughter, aged seven years, was staying with Joyce's mother in Louisiana, partly for financial reasons. I never determined the other part. Joyce was quite alone and missed her daughter “too much.” Still, she seemed to have some ambivalence about the situation.

Joyce thought her general health was “pretty good.” She had, however, undergone a total hysterectomy some months previously for reasons which are now quite forgotten by me. Joyce showed little emotion during the interview, tearing but once when speaking of her
daughter. She did admit to occasional moments of loneliness and depression. Joyce took no medication routinely and had not been offered estrogen replacement (standard *practice* at the time) when her ovaries were removed during her recent operation.

Joyce generally worked as a store clerk, but had recently moved to a new job. There it was. The obvious, outer cause of her chest pain. It had been entirely overlooked by the psychiatrist-turned-family practitioner in his undoubtedly brief and hurried moments with Joyce. You see, Joyce had only a few days previously taken on new work as an elevator operator in an old downtown office building. Joyce’s job was relatively easy, taking people up and down the building levels. “Oh, I don’t mind it. I kind of like it.” Joyce merely had to conduct people, push buttons, and manually open and close the elevator door using her left arm. Open and close. Open and close with the left arm. Open and close.

The obvious cause of Joyce’s chest pain was missed because the resident physician was concerned about and looking for a heart attack: rather unlikely though it was in a woman in her thirties. In Joyce’s situation, a heart attack was unlikely, a muscle strain and pain due to relative overexertion was more common sensical. Joyce was not unusual, nor was her problem. Yet, she was a unique person who deserved more than a simple cookbook approach to a significant incident in her life.

There were deeper dimensions to her story which I didn’t fully realize at the time. One dimension related to her hysterectomy and inability to bear more children. Joyce had suffered the loss of ovarian hormones and the disruption of function in her whole reproductive and endocrine system due to her surgery. More importantly, she was trying to deal with her separation from child and husband. All those factors were no doubt affecting her and must have contributed to her chest pain and “heart ache.”

My contribution to Joyce’s well-being was limited. I did get her started on estrogen replacement (standard *practice*). I saw her in the clinic and spoke to her over the telephone from time to time. I should have visited Joyce in her home surroundings. I did listen to her and encourage her attempts to improve communication with her daughter. I shared her life in a small way and for only a short time. But,
hopefully, I did so in a humanistic and caring and somewhat artful
manner.

Looking back over many years, I wonder whether a third-year medical student didn't have for a moment more of a sense of authentic medicine than a man completing his second residency. Regular Physicians often follow form and quickly go into testing mode. If a third-year novice can find a simpler, less expensive, and yet caring way to deal with patients, so too can fully trained physicians.

And, Mr. Voltaire would be the happier that physicians practiced another of his pithy quotes: “The art of medicine consists in amusing the patient while nature cures the disease.”

**Insuring Care?**

Health Care and Health Insurance have many obvious connections as well as a subtler one. The latter being that they are both oxymorons.

Really? Really!

Let’s start with Health Care: From the author’s vantage point, there is no such thing as Health Care. How so?

Doctors don’t really DO Health Care. They don’t study health and they don’t know what health is. Many would admit that to be the case. They might even say, “Health? Why, that’s not my job. I work with people when they’re sick. If you’re interested in Health, go to the Wellness Center.”

Since Wellness comes up, we might address that too. The Wellness movements are worthy and generally point in positive and hopeful, even healthful directions. “Small steps in the right direction,” you might say.

But Wellness, like Prevention, is an unwanted stepchild of Father Medicine. Both get little in the way of attention, money and research in most medical circles.
Wellness programs rarely have much physician input, again because docs don’t know much about it. Practically no one does. Besides, “Wellness doesn’t pay well.” Para-professionals take on Wellness and do the best they can with limited resources and also limited knowledge. Physicians certainly don’t want to be put out of business. Health and Wellness are not in.

Most Wellness programs are hodgepoodles of stress relief, exercise, nutrition, weight reduction, smoking cessation, and alternatives classes. There is rarely an over-riding Health philosophy to such programs.

True Health and Wellness efforts require some investment in Health philosophy. Wholeness as another name for Health touches on matters of spirit and religion which are other areas of which materialistic “workers in disease” must beware.

Physicians really don’t care for your Health. They are in Disease Care mode and focused almost exclusively on disease. Generally speaking, the few efforts made in a medical office towards Health are left in the hands of nurses and assistants, literature and video material.

Health to many Regular Physicians remains “the absence of disease.” They weren’t trained about Health - and still aren’t. Even if they had been, they would have rebelled against it. “Health class? The profs are taking us back to high school days,” I’m sure medical students would say.

The closest med students get to Health is in Physiology class where the body is “broken” apart into systems. Physicians-to-be learn about normal function of body parts and systems. They can tell you about blood counts, arterial pressures, urine outputs, respiratory rates, and the like. Both normal and abnormal. But, Health for a whole being is not addressed. This is one of the Big Gaps in medicine, past and present.

Generally speaking, medical training and medical students are focused on the “meat and potatoes” medicine which equates to pathology and disease, blood and guts, cutting and curing, saving lives. Not “salad and vegetables,” like prevention and health oriented topics.

This reminds the writer of his days taking Basic Sciences in med school. The curriculum called for a number of hours in Computer
Sciences. Can you imagine such a thing?! John Lenahan, Ph.D., led us in a few hours of classroom studies involving computer applications along with some lab exercises meant to teach us rudiments of computer programming. A very modest introduction to the subject.

You should have heard the grumbling. “What has this got to do with medicine? We will never use this stuff.” How little did they know - any of us know - how important computers would become in modern life, including medicine, in the coming years. Health is/was surely an even more important topic for medics, but one for which there was not a single class provided.

True Health is a Big Picture thing which requires people - physicians or patients - to look beyond illness and problems and the body. It takes time and a different orientation.

YOU don’t go to the doctor’s office when you are healthy, generally. The vast portion of medical visits are for illness and injury or followup appointments. Healthy people don’t take the time to see their practitioner except for annual physical exams and vaccinations. Many people don’t even do that.

So in a sense, YOU are part of the problem. Unless YOU take Health seriously. Then, maybe you really don’t need to spend much time at all with our present Disease Care system.

Disease Care prevails because of our general mindset, because physicians have disease on the brain, and because fear rules in society and in medicine. The road from Disease Care to Health Care will surely be a long one.

The other side of the coin - and this chapter - is Health Insurance. Which is also an oxymoron and presents similar ideas for consideration by thoughtful, frugal and prudent people.

The Industrial Era has brought us to a period where we are controlled by our imagined futures. Business and commerce have been forced to prepare for our retirements and illnesses. Forget health. Aging
and disease and death are of supreme importance.

Thus, millions and millions plan their lives around so-called health insurance, IRAs, investment portfolios. “I must have it all planned out before I leave my job and retire.” “My Roth IRA is a slam dunk to take care of my future needs.” “I can't change jobs unless the new one has health insurance.” “The job isn’t important, even if I hate it. It's the benefits.”

The media is forever reminding us that Social Security is inadequate and no one has enough insurance. For the richest country in the world to have “so little” seems ironic and paradoxical. How much is enough?

No one seems to earn enough (have you ever met anyone who willingly admits to earning more money than s/he needs?), and most everyone spends too much. And while we all get sick and die, most of us think the doctor and the hospital have magic bullets to save us from pain and delay the inevitable.

We have bought into the idea of retirement packages, financial planning, and health insurance like other withering fairy tales akin to Happily Ever After. Hollywood, Wall Street and the Mayo Clinic mentality have led us down the path towards a supposed unending bed of roses. While the Western systems have held up remarkably well for many decades, it is clear that many of those systems are near the breaking point.

Stock brokers will admit that their business is all based on paper. No common stock has any intrinsic value. Insurance policies are promises to pay. Promises are not always kept. Pensions are not always honored as written. We see that in the present day. Likewise, insurance packages are simply not what they are touted to be.

Health Insurance is akin to Life Insurance. They both sound good, positive and wholesome. But, they are both deceptive. Life Insurance is clearly Death Insurance. What about Health Insurance? You got it. It is most assuredly Disease Insurance.

The simple fact is that HEALTH INSURANCE does not exist! Neither insurance nor the greatest physician in the world can assure your health. People fall over dead the day after getting a clean bill of
health from their doctors.

More physicians and more medicine will never assure your health. Sometimes they can help, but they may also do more harm than good. You might just reflect for a moment on the general states of health of medical professionals. They are not a particularly healthy lot and succumb to all sorts of diseases, addictions, suicides.

We get used to things as they are and often don’t notice that “A spade is not always a spade.” Health insurance is surely a misnomer. It is simply Disease Insurance. It insures that when you feel bad, get sick and think you need a doctor, you will be able to use his/her services without paying the whole bill for all the appointments and tests and procedures which result when you consult your physician.

Your Disease Insurance does a number of things, some of which you most likely have never considered.

- Disease Insurance promotes using the medical system and, in fact, grows the system. “Ah, I got insurance. I have two policies. It won’t cost me a nickel to spend a few minutes with the doctor.”

  Insured patients prompt physicians to order more tests, probe to the extent of coverage, and make full use of insurance. Self-payers think twice before venturing into the system. They save money and lower patient volume at medical offices.

- As the system has expanded and grown, all sorts of things have crept into “standard practice.” Like more paperwork, more paper workers, more intrusion by insurance companies. Standardized care has replaced personal care to a large degree.

  Third parties, like Disease Insurance companies and Medicare and Medicaid, also make more and more medical decisions. That is so regardless of what kind of physician you consult.

- Disease Insurance supports more testing and operative procedures. Certain diagnoses mandate certain patterns of testing. Insurance companies have to protect themselves (CYA), just like Regular Physicians. Medical insurance has much in common with malpractice
insurance. They both are intent on protecting against the worst, however unlikely such may be.

Thus the volume of procedures increases as do the number of them available for your physician to choose from. The whole mentality proceeds to growth and duplication and re-duplication of testing. Many tests are repeated needlessly and wastefully. Charts get voluminous and report files get thick. Often with little valuable information rising out of the mass of paperwork and technology.

AND, you guessed it. All this activity adds to costs to the patient and, directly or indirectly, to increased physician income.

• The Disease Insurance that many people are proud to own actually empowers the concept of disease and supports the disease model of modern medicine. Insurance enables physicians to search for and find more diseases, ailments and conditions to treat.

A large proportion of those conditions may not warrant treatment. Another portion may be made worse by intervention. (The treatment may be worse than the disease.) And then, there are the ill effects which are common in therapy of all sorts of problems. Even a sugar pill can have side effects.

• Disease Insurance adds to the medicalization of life, spreading tentacles hither thither and yon. Medicine and testing thus become required to apply for many jobs, to play little league baseball, to get married, etc. Medicine intrudes everywhere and in so doing finds as well as creates more disease.

Disease hunts become increasingly common. Diabetes gets promoted through Diabetes Month. Depression gets a nod through Depression Screening Tests. Another telethon is begun, another benefit produced. Disease is not lessened, but really increased.

A Frugal Physician is aware of the contradictions implicit in words like Health Care and Health Insurance and so should you be. Disease Care is necessary, but tell it like it is. Do the same with Disease Insurance until Health becomes key in medical practice.
Bizness

Medicine has become business - Big Business. The medical system is overgrown, super-specialized, hyper-technical, papered over and out of control in many ways. Reform is in the air. Legislation - to “fix” the system - which has been debated for decades, has been passed at the federal level in the USA.

But Federal intervention is likely to have little real effect on the expensive state of medical care, much of which is ineffective and off target. At the rate things are going, we will continue to have more medical care, more technology, more bureaucracy, and more insurance of one kind or another.

More medical care (disease care) - more of the same - is hardly the solution. Science and technology have brought us into an era of problems in medicine akin to ones in our military system. Surely, it is better to put money into hospitals and medical technology than into guns and weapons. But, neither seems to be particularly effective in dealing with modern society and its real challenges. They both have been promulgated out of fear and add to massive waste in our modern life.

More than fifty years ago, President Eisenhower warned of a developing Military-Industrial Complex. He saw it coming and the first MIC has long since become part of our everyday world. Bigger weapons - including nuclear warheads and missiles - were supposed to protect us and keep us safe. But, they may have done the opposite. Business interests have steered a great deal of policy with regard to national defense and military power, war regalia and weapons procurement.

Now, similar forces have brought us MIC II: the Medical-Industrial Complex. The general thinking is like, “We have protected the nation and the whole Western world with missiles, fighter jets, and modern technology. We can create comparable wonders in clinics and hospitals with smaller doses of Big Tech.”

In actual fact, medicine hasn’t kept up - with or without technologies
- with many other sciences. As a society, we might question: “Have the trillions of dollars spent in medical care and research in recent decades paid off?” “When was the last time, we heard of a ‘real cure?” “Have all those million-dollar scanning devices - CT, MRI, PET - made substantial differences in quality of life for those who spend big money on them?” “Has the extension in lifespan of J Q Public brought more health or just more years?”

The wonders of modern medicine are too often ones which leave individuals wondering: “What did I get out of all of those tests?” “Why did I let them put me through all of that rigamarole?” “Just one more procedure. Then, one more. How many more can there be?” “What did I pay those thousands of dollars for? I have the same problems plus financial ones now.”

Medical technology has helped bring about the huge expansion in medical business. Every level of the profession is affected. And this force has rolled on into almost every aspect of our lives.

The changes are most obvious in big clinics and hospitals. But, they affect - maybe infect - the smallest of medical operations.

• For practical purposes, the old time GP is history in the USA. S/he has been replaced by Family Practitioners who are supposed to be generalists. These FPs are intended to be the modern version of yesterday’s General Practitioners.

But curiously in these days, a generalist becomes specialized - board certified in Family Practice. That sure seems like another oxymoron to me. What do you think?

• The general effect of this state of medicine is for Family Practitioners to only treat patients with very simple problems. And others that have become chronic. Those which the specialists pass back to the Referring Physicians.

Still, Referring Physicians are theoretically important to the system because they keep patients in the pipeline to the real specialists. But more and more, consumers make their own referrals and try to bypass physicians at the lower echelons of care. They think, “Why should I
waste time and money with Dr. Doe, when I know he is going to refer me up the line, anyway?”

The old time doctor just has a tough time keeping a toehold because of the flow of the modern medical system. Exceptions are in remote and rural areas and where conscious physicians make choices to do things differently, regardless of consequences with the looming system.

It is harder for most solo practitioners. They have to compete for patients. They have to do things just like the big boys and clinics, order and refer, order and refer. It is harder and harder for imagination and compassion to find room in the system.

When patients start having more imagination of their own, they will help the situation by seeking providers who have imagination as well as common sense, compassion and competence.

• Few simple remedies are used anymore. Poultices, rubdowns, sponge baths, salt packs and the like are almost ancient history. “Why should we do things manually when we can do them with machines and medications? Medications have been manufactured to the highest standards of quality. A person can not be sure what goes into those herbal preparations. They are not purified and refined like pharmaceuticals. I dare not recommend such things!”

Old time, hands-on treatments are out, in part, because their value is hard to prove. Numbers and statistics and paperwork rule. Still, real proof is not to be had either with standard practice or with alternatives. And human contact and touch are becoming as nought. Or almost so.

• Technology is king. There is a test or procedure, or battery of them, for practically every ailment. And, they certainly must be used. “Because that is the modern standard. This is the twenty-first century. No ailment need go untested.”

“Bigger is better,” so we have been told. But, we are beginning to recognize that ain’t necessarily so. The new methods are meant to improve things. But, then there is less and less time for face-to-face contact with patients. “Yes, but there is a waiting line. Anyway, we go by results. And if not results, by numbers.”
• Speed is of the essence. That is part of the reason we have Air Ambulance programs. Helicopter evacuations were developed in war zones for serious casualties with no other transportation access to get prompt care.

These days, such services are grossly overused and dramatically increase medical costs. How many times have I seen helicopters pick up patients who could have been transported just as easily by ground ambulance! Sometimes, more quickly.

This common situation was brought home to me as I saw a rancher friend drawn through the “faster is better” medical system. This middle-aged man had been thrown from his horse while he was moving cattle one spring. John got back on his horse and continued down the trail for most of an hour. Eventually, the hardened herdsman was in so much pain that he asked to be driven into the hospital which was about seventy miles away.

A friend did the duty, but stopped at a small town twenty miles en route. Before a person could turn around, EMTs were collecting, administering oxygen, placing a neck brace on him, and putting him on a hard backboard. (standard protocol) Instead of driving him the rest of the way into the medical center, someone decided a helicopter ambulance was needed.

It took much longer to get him moved by ambulance - to a landing area and then helicoptered 45 miles to the medical center than it would have to simply take him direct by ground ambulance. Two hours had passed since the incident occurred. (Interestingly, the latter vehicle is called a Quick Response Unit.) John’s travel bill was certainly increased tenfold. He was found to have a lacerated kidney which resolved on its own. His body took care of the problem while he was tested for several days in the hospital.

• The modern medical business feeds on itself. Offices require larger staffs. Overhead goes up. More patients are required or patients pay more because office bills expand. Or both.

Hospitals have so much expensive equipment which soon becomes outdated, have to meet the highest building codes, and compete with
neighboring facilities to be the best in the region.

• Medicine, furthermore, is monopolistic. The modern medical monopoly makes the system monolithic and hard to change (it is actually duolithic - drugs and surgery). Almost all questions of health and disease are decided within the confines of an inbred system which has little external input, attention or control.

Peer Review supposedly governs medical work and issues. But, physicians rarely bother each other in their work. Certainly, non-physicians - excepting legislators and insurance companies - have practically no say in major medical concerns. Malpractice and non-standard practice and drug abuse are notable exceptions.

• Consumers have no say regarding the costs of their medical care. Too often they don't have an inkling what their bill will look like until they see it in the mail. Costs and bills thus can’t help but rise.

Your Regular Physician is a businessman whether s/he admits it or not. But, s/he has absolutely no training in business. Physicians are notoriously bad business people. They weren’t helped at all by their training which likely never had an hour devoted to medical business, costs of services, and patients’ generally unspoken need to have their finances considered as part of their state of health.

The “business of medicine” has large implications. A Frugal Physician makes it his/her business to ask about patients’ financial situations. True health surely encompasses a host of forces.

In the future, the business of medicine inevitably will be more about:
• people than paperwork
• persons and not just bodies
• patients and not merely diseases or cases
• simplicity rather than complexity
• comfort and compassion ahead of diagnosis and treatment
• the whole person including his/her wallet
• the profession of healing