

The System Will See You Now

Jeffrey Hall Dobken, M.D., M.P.H.

Roughly eight weeks ago the world changed colors and the horizons moved, instantaneously. It was as life-changing a moment as the day my beloved collie had the sudden seizure that would end her life. Binoculars would now be used only through the wrong end. The diagnosis was IgA kappa-light chain multiple myeloma, stage III as I later learned, revealed by chance on a pre-op blood test ordered for pending orthopedic surgery. I had cancer. I mutated—from physician, caregiver and parent, to patient.

This story is about the transition and emotion of this metamorphosis, in the age of “healthcare reform.”

Early shock, disbelief, and denial were the first emotional responses, and to some extent, all continue. Elisabeth Kübler-Ross notwithstanding, denial, isolation, anger, withdrawal, depression, are all intermixed. Aging has always meant dissolution of the endless promises born of our youth, but the timeline was unpredictable. Cancer removes the unpredictability and accelerates the loss: the horizon is no longer limitless nor far away; the plank has been significantly shortened. Will this be the last sunset, sunrise, winter, spring, Halloween, Thanksgiving, Christmas, Rosh Hashanah? Will this be the last bike ride? The last run? The last lap?

We spend a great deal of our existence defining ourselves and the meaning of life. Truth is always difficult to manage when it comes to defining our actual role and contribution in the broader fabric of existence. Some find religion, some find causes, some find clubs, some find wealth, some find politics, but most in our culture ultimately craft a persona that appears right and seems comfortable, and then is transmitted as the living image communicated to our peers. Appearance counts far more than substance, as the defining characteristic of the 21st century’s Facebook virtual personality. Too bad Mario can’t really grab a few more lives while hopping from stones and turtles to clouds and whatever.

So what defines a doctor in our world of hope and change, our world of “healthcare reform”? Despite a medical career spanning more than four decades, that question still makes me uncomfortable. Define yourself: what kind of a doctor are you, anyway? The answer generally is greeted with an anecdote or personal problem that somehow, in order to be a kind doctor, requires an instantaneous opinion, as a test or freebie or proof of humanitarian motives. Remember, health care is a right, we are informed by Courtney Keeler of the University of San Francisco as “Liberation Health,” and should be accessible and affordable as the automatic “ethical” extension of our birthrights.¹

Somehow it is assumed that the “privilege” of a career in medicine—a complicated, three-dimensional profession that

requires making decisions in a world of uncertainty—obligates one to be endlessly serviceable no matter what the casual occasion. Somehow the accident of existence automatically entitles one to demand an equity position in healthcare resources, constitutionally implied, and a quantifiable share of “social justice.” Worthiness is assumed; personal responsibility for one’s life does not enter the equation.

Absent from the calculation is any consideration of the personal responsibility of self-sacrifice, dedication, and discipline needed to become a physician, requiring years of training, education, and apprenticeship before the career would actually begin.

So what is a physician, the “provider” in the language of mandated healthcare reform paradigm?

The Beginning of the Divide

To help comprehend the new norm in medicine, let’s visit ancient Greece.

It’s really quite an ancient debate: four to five hundred years before the birth of Christ, on the island of Kos (home of Hippocrates), the myth of Aesculapius, god of healing, son of Apollo and the nymph Coronis, originated. As often happens in Greek mythology, Coronis meets a violent death, but the infant Aesculapius is saved, raised by a wise centaur. He becomes skilled in healing arts, and succeeds in bringing a patient back to life. This act threatens Zeus and the god’s ownership of immortality, so Aesculapius is promptly placed among the stars as Ophiuchus, the serpent-bearer. The serpent on the staff of Aesculapius became the symbol of medicine.²

The children of Aesculapius included his goddess daughters Hygeia and Panacea, who were the symbols of hygiene and healing. These female figures, especially Hygeia, focused on prevention and public health, which created a tension with and for their father and was characterized by George Sheehan, M.D., in 1984:

Medicine is divided into two camps: public health and private practice; the disciples of Hygeia, goddess of health, and those of Aesculapius, god of medicine; those who would prevent death and disease and those intent on curing it. One camp is concerned with humanity; the other with individuals.³

American “Healthcare”

U.S. healthcare reform legislation, the Patient Protection and Affordable Care Act (PPACA or ACA), might be viewed as

an extension of this ancient dialogue. But healthcare reform is a dysphonic concatenation. It is not presented in a logical, cogent, or orderly fashion, perhaps because of emotional content or political posturing or personal feelings that all too often overtake the discussion. In reality, American socio-cultural reform blends moral and political concerns with the demands of economic efficiency, as social engineering is not effectively achieved by fiat or mandate.⁴

Medical care is decidedly different from the current American definition of “healthcare,” which actually refers to insurance plans and payment, not patient care. “Healthcare reform” has been crafted as a means to control physician fiscal comportment by defining physicians not as professionals governed by a strong ethical code, but as merchants who sell their goods and services to customers.⁵

Could it be that the current crop of physicians bears direct responsibility for these notions? Just listen to any media outlet for the doctor, the treatment, the hospital system, and the insurance plan, the ACO or HMO, the newest “just-ask-your-doctor” medication, etc. that guarantees better results only if you go there first. The net result is a climate that fosters suspicion and distrust of an avaricious medical profession in contradistinction to the self-described non-avaricious public health community empowered to control the ebb and flow of the new medical industry. The public health community can provide statistical evidence that treatment designed for the average patient saves a lot of money for the system, reduces medical fraud and abuse, and permits central planning.⁶

Seeing the American medical professional as the culpable agent of expensive medical care, exploiting diseases with costly and unnecessary procedures under the guise of medical necessity but actually little more than instruments of personal greed in a bloated fee-for-service system, has been the implied cynical message. What is the solution to this perceived dilemma? Eliminate the private practice of medicine: replace the doctor. William Hsiao, Ph.D., of Harvard calls for a single-payer solution to “eliminate the perverse incentives inherent in the fee-for-service system,” and joins the chorus of voices that characterizes all American healthcare as “fragmented.”⁷

This legislative and political maneuvering aims to replace the physician with a series of “physician extenders”: the nurse-practitioners, the physician assistants, the trained medical receptionists, the medical “navigators,” the masters of public health with certified health educator status, et al., together with a battalion of functionaries and bureaucrats. These are needed to perform “healthcare services” within protocol processes, to gain prior approval, and to evaluate adherence to PQRS guidelines or otherwise police the “physician greed and corruption” that has been advanced as costing Medicare and Medicaid \$300 billion dollars.⁸ Sounds ever so much less fragmented, doesn't it? And efficient, too!

An embedded goal of ACA and healthcare reform is to contain and control physician fiscal comportment. This is framed as decreasing cost, increasing access, and creating accountability, and the key mantra, achieving “sustainability.”

It's just not very clear how this is accomplished or by whom it is defined, other than by the bureaucrats in charge.⁹

The Patient's Perspective

And this is the turbulent climate into which, after decades of practicing non-stop hands-on clinical medicine, I transition from physician to patient. Scary.

Since Oct 7, 2015, I have met that small army of physician replacements (at least the ones with the really good ads and public relations relating to cancer and multiple myeloma) and have begun the marathon gauntlet of cancer treatments from medical procedure to medical procedure, called from waiting rooms by my first name, meeting yet another total stranger who will ask me my name and date of birth, then look up my diagnosis in the computer and start the intravenous infusion that will introduce poisons that I wouldn't touch without gloves. The system has its plan.

But for the patients and all their nameless and faceless fears, the anonymity required by the system (HIPAA law, you know), stripped of their dignity by the disease as well as the side effects that the treatment produces, the impact on one's loved ones, the dissolution of one's self-image—all the things the clinician knew, anticipated, or intuited as likely to occur—where is the patient-physician bond to foster the needed caring and comfort, the empathetic intervention to blunt the disease's impact on patient and family? Such was not only considered therapeutically critical in the medical training of not that long ago, but was extended automatically and routinely, not as an add-on charge. And it was not a science project, but an extension of clinical morality and hallmark of the able clinician and healing professional, like Harvey or Gussoff, who advanced patient care with courage, compassion, intellect, knowledge, and heart so that the physician could act as the bridge through adversity, anxiety, and pain. It was called “trust.”

But since these services cannot be coded in the new medical norm, they simply don't exist. Or, if pre-certified, the patient can be referred to a psychologist or social worker for counseling. The care is mechanical, automated, cold, and indifferent, just like the disease. But Americans supposedly wanted and/or needed a new “ethical” health care “system” as a matter of social justice. The system will see you now. The physician has not been pre-authorized.

My studies as a physician allow me some insight into this process, looking behind the curtain, but this is a mixed blessing—I know too much yet too little: an advantage and a curse. My reading of my data and applicable cancer literature has an old school observer's dispassionate gaze that defines survival in months plus or minus a margin of error. But at the same time, my wife and children have me seeking the statistical brass-ring escape valve, and surviving against the odds. I no longer know what side of the glass I'm on, but I have not found comfort or solace on either side.

My family turns to me, as it has for my entire career, for medical information and reassurance, and I find myself wanting

to reassure, but reluctant to misinform. I mastered a semi-evasive dialogue as I perceive that the emotional needs of my family are not served by my schizophrenic roles any more than by a discussion that reveals the blunt truth. The hardest task I have faced in many a year was telling my son and daughter that I have cancer.

The treatment process is long, and I have just begun. I know that the care that I am receiving is state-of-the-art, competent, and, in system-speak, well within parameters. Since there really isn't a GPS for the journey, and the destination and the time of arrival are unknown, the commitment to the process will require a concerted personal effort. I know that others with this disease have companion groups, and have learned to cope through any of dozens of mechanisms. I must as well. It is simply that the future is not what it used to be, nor is the profession of medicine.

For my family, from Emerson:

To laugh often and much; to win the respect of intelligent people and the affection of children; to earn the appreciation of honest critics and to endure the betrayal of false friends; to appreciate beauty; to find the best in others; to leave the world a bit better; whether by a healthy child; a garden patch or a redeemed social condition; to know even one life has breathed easier because you lived. This is to have succeeded.

We must and will do the best we can, and maintain dignity no matter what, to make the best possible use of the small slice of eternity we are given.

What Kind of Doctor?

So what kind of doctor am I? I'm an Oath-taker and believer:

I swear by Apollo the physician, and Aesculapius, and Hygeia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgment, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they be free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep a secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate."¹⁰

In my mind, there is no more elevated a calling or noble a career than the profession of medicine, my dream since childhood, the direction of all my life force and efforts, the encapsulation of dedication and purpose of my life, and my singular and sole identity and mission.

Jeffrey Hall Dobken, M.D., M.P.H., was a practicing allergist in N.J. and holds a certificate in bioethics from the Center for the Study of Society & Medicine, College of Physicians and Surgeons, Columbia University. Contact: jhdobken@verizon.net.

REFERENCES

1. Keeler C. Liberation health and the role of the public health leader. *Open J Leadership* 2013;2(4):82-84. Available at: <http://dx.doi.org/10.4263/ojl.2013.24012>. Accessed Sept 24, 2014.
2. Williams NW. Serpents, staffs, and the emblems of medicine. *JAMA* 1999;281:475. Available at: <http://www.medspirit.com/logo/emblem/index.htm>. Accessed Dec 9, 2015.
3. Sheehan G. Two camps unite. *Physician and Sportsmedicine* 1984;12(5):39.
4. Cooke M. Cost consciousness in patient care—what is medical education's responsibility? *N Engl J Med* 2010;362:1253-1255.
5. Annas GJ. Quinlin: a twenty year retrospective. Syllabus. Center for Continuing Education, University of Medicine and Dentistry of New Jersey; 1996.
6. Boyer RG. Public health in the precision-medicine era. *N Engl J Med* 2015;373:499-501.
7. Hsiao W. State-based single-payer health care—a solution for the United States? *N Engl J Med* 2011;364:1188-1190.
8. Levinson DR. *Medicare Overpayments Identified By Program Safeguard Contractors*. OEI-03-08-00031. Office of Inspector General, Department of Health and Human Services; May 2010. Available at: <http://oig.hhs.gov/oei/reports/oei-03-08-00031.pdf>. Accessed Aug 18, 2010.
9. Cohen JT. It's not the 'shared savings,' stupid: why ACOs under the proposed rule will change medicine as we know it. *Health Reform Watch*. Seton Hall University Law School; Apr 17, 2011. Available at: www.healthreformwatch.com/2011/04/17/its-not-the-shared-savings. Accessed: Apr 19, 2011.
10. North M. *Translation: the Hippocratic Oath*. History of Medicine Division, National Library of Medicine, National Institute of Health. Available at: https://www.nlm.nih.gov/hmd/greek_oath.html. Accessed Dec 9, 2015.