



## **The Best Possible HealthCare, Part 1.**

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### **Abstract**

The legislation that was passed in the US may have expanded health care coverage, but it will not bring patients and their physicians into a more healing relationship. That will require expanding the current paradigms of medical care. This article will examine Disease Focused Medical Practice (DFMP). It will describe two other healthcare practice systems, Life Force Focused Practice (LFFP) and Patient Focused Medical Practice (PFMP), showing how recognizing and properly utilizing concepts and approaches from these other practices can help achieve the best possible healthcare and improve the experience for both patients and doctors.

Key words: Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP). Patient Focused Medical Practice (PFMP), best possible healthcare, ideal doctoring.

*If I have seen further than other men, it is because I have stood on the shoulders of giants.*

- Isaac Newton

*To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.*

- William Osler

*Anybody who wants to make things better is a rebel; any rebel who is not in trouble with the establishment is lying down on the job.*

- Author unknown

*Do not worry about what the world wants of you. Worry about what makes you come alive, because what the world needs is people who are more alive.*

- Larry LeShan

### **Perspective**

When Electronic Medical Records (EMR) was introduced into medical care, it was said to improve the quality of patient care. The concept and measurement of quality of care is very elusive, and studies have failed to find consistent improvement in patient care attributable to EMR. What studies have found is that "primary clinical work may be made less efficient (Greenhalgh, 2009), while at the same

time costing billions of dollars. If a new medication were introduced with such borderline efficacy and with astronomical cost, it would have been declared not cost effective and, in all likelihood, would not have been reimbursed by insurance companies. Since government, insurance companies, economists, academic physicians, and others involved in EMR, have failed to produce a cost effective method to improve patient care, why not turn to the actual practitioners who take care of patients to see if they have any ideas to achieve the best possible medical care? This paper explores ideas and suggestions of an internist, stimulated by caring for patients for over 40 years and is meant to stimulate reflection from patients (we are patients at one time or another) and practitioners.

## Introduction

We all want the best possible healthcare, whether we are doctors wanting to practice it or patients wanting it when needed. With modern technological advances, many people who in the past would have become severely incapacitated or died can now recover and live. The average lifespan a century ago was 48 years; today it is over 78 years in the United States. We should be happy and grateful for modern medical achievements and many are. Yet today, many doctors and many patients are unhappy.

Today's healthcare (more accurately disease care) industry often frustrates doctors and other healthcare professionals. With the need to control the cost arising from the explosion of medical technology, and with changes in market forces, doctors today are often forced to answer many questions from insurance companies before they can order tests or hospitalize patients. Often, the questions are asked by insurance company employees who are not healthcare professionals and who do not understand why particular tests and procedures may need to be done. And doctors become frustrated trying to explain why they want to do something to a person who does not understand patient care.

To protect themselves from possible future medical-legal actions, doctors may feel forced to practice defensive medicine and order extensive testing that increases healthcare costs, and to provide patients excessive medical facts that may unnecessarily worry them. When we hear doctors saying, "same stuff different day", it is apparent that they have lost the joy of interacting with other human beings, the privilege of entering into the drama of their lives, and the satisfaction of helping them in their journey through illness.

Patients are also frustrated, for many reasons that are beyond their doctors' control: the cost of insurance and medications; coping with a medical system that is increasingly fragmented and impersonal; the short time allotted for visits; dealing with the media bombardment of medical information that is often contradictory.

Older doctors and patients, who can remember their experiences from years ago, feel more frustrated with medical care today.

Is *all* the unhappiness the inevitable result of the scientific progress of the last century? No. Some of the frustration for both doctors and patients is because *the focus of medical care today is primarily on the disease the patient has and not on the patient who has the disease*. This is such a deep-seated and subliminal assumption that we often do not recognize it.

A closer look at the language of medicine unmask some of these issues: When a test result is normal, doctors call it negative; when the result is abnormal and/or indicates that disease is present (such as cancer), it is called positive. However, from the perspective of patients, knowing that they have a serious disease is a negative experience, not a positive one.

This purely biomedical focus begins with medical students' initiation in their first course in medical school: Anatomy – dissecting a dead body. This sends a dramatic (if unintended) message to the young doctor-in-training about the importance of knowing about the structure of a patient's body, without balancing it by also teaching the doctor-in-training how to listen to a patient's story of their illness. Some medical schools have factual courses titled introduction to medicine, but that is no substitute for the actual experiences of observing caring clinicians interacting with the people they are examining and treating; for taking time to discuss with people, whose bodies students are examining, how they feel about their presenting problems; and of course, through the process of being a doctor.

A basic assumption of this disease-focused view is that *patients will get better if we find and treat their diseases*. Therefore, a doctor's primary focus is to study diseases and their treatments. This is emphasized throughout medical school training. It then continues to be the primary focus of peer reviewed medical journal articles, which emphasize clinical guidelines, evidence-based medicine, and formal studies that are subjected to statistical analyses, meta-analyses, cost benefits assessments, etc. Because of the centrality of disease and its treatment, *the experience of being a patient and the experience of practicing medicine* are devalued and sometimes ignored. Furthermore, clinical judgments of doctors are not given the respect they deserve by insurance companies.

The legislation that was passed in the US may have expanded health care coverage, but it will not bring patients and their physicians into a more healing relationship. That will require expanding the current paradigms of medical care. This article will examine Disease Focused Medical Practice (DFMP); it will describe two other healthcare practice systems and show how recognizing and properly utilizing concepts and approaches from these other practices can help achieve the best possible healthcare and improve the experience for both patients and doctors.

### **Disease Focused Medical Practice (DFMP)**

The DFMP system of healthcare is less than four centuries old. Thomas Sydenham (1624-1689), seeing how plants could be classified according to common features, classified diseases by what were called pathognomonic symptoms, i.e., symptoms present in all patients with that disease (Reiser, 1978). Symptoms unique to the individual patient, idiosyncratic symptoms, were devalued and ignored. When Isaac Newton (1642-1727) developed his principles for the study of matter, the body came to be viewed as a machine, and today, doctors commonly talk about “tuning up” a patient. René Descartes (1598-1650) split the mind from the body, claiming the former to have no connection with, or influence over, the latter. Subsequent scientific developments included the core concept of *reductionism*: by studying smaller and smaller structures and body reactions, researchers produce advances in understanding physiological and pathological processes and in treatments. DFMP is the system taught in medical schools worldwide and in the US it is also taught in osteopathic schools. It is also the basis for the reimbursement methods used by Medicare, Medicaid, and other insurance companies.

The goal of DFMP is to find a lesion and treat it: kill bacteria or cancer cells, remove cancers or infected gallbladders, and replace insulin if it is inadequately produced in the body. Disease is viewed as separate from the person. A hierarchical approach has developed in which the practitioner is in charge and the patient is (patiently) passive. Accompanying the enormous growth of factual information about diseases and their treatments has been the growth of specialists who know more information about a limited field. With the growth of technology, many specialists have dealt with uncertainty (a fact of life and of medicine) by ordering more tests, often to rule out disease, often without considering the implications of possible results. Imagine a prospective medical student, responding to a question on a medical school application asking why do you want to be a doctor, replying, “To rule out disease”.

The accomplishments of DFMP are so much a part of medical care today that they can easily be taken for granted, until we have a personal medical experience or a news story captures our attention. The accomplishments of DFMP have significantly contributed to the treatment of diseases and injuries. With neonatal ICUs, babies weighing only 1 1/2 pounds can now survive. With trauma units and trauma surgeons, victims who might have been killed or maimed by serious injuries now survive and recover. Patients with impending heart attacks can now be “stented” and return to their homes, often the same day, without having suffered damage to their hearts from that episode. As a primary care doctor, I depend on, and am grateful for, the excellent care that specialists give to my patients. I am also grateful for specialists answering my questions about my patients –teaching me about the latest in their field.

Yet, there are distinct limitations to what DFMP can do, and sometimes there are unwelcome consequences. Patients still die, many in pain, and many in the impersonal surroundings of a hospital. Hospice and palliative care are undervalued, underutilized and frequently utilized too late – only after unnecessary suffering. Even with the advances of DFMP, many chronic diseases are still neither cured, nor controlled, leaving patients with suffering and disability.

Over the last four centuries, the history the doctor obtained directly from the patient has been devalued in favor of the doctor examining the patient with tools (stethoscope, etc.) which in turn, were devalued in favor of relying on data collected by machines that could examine patients without the doctor present. Even if medical students are well trained in history taking, the reality is that today, in actual clinical practice, laboratory tests and imaging, often used to rule out disease, play increasingly large roles. The separation of the disease from the person has produced depersonalization between “providers” and “consumers”. Thirty percent of Medicare costs are expended on the last thirty days of life and over fifty percent on the last sixty days (Lubitz, 1993), often to no avail, and at great personal cost and discomfort to patients at the end of their lives. While this does not mean withholding reasonable efforts to treat patients who could recover, over-treating patients in some situations is futile. A rather extreme, but not unheard of, example is the use of kidney dialysis for a demented patient, who doesn’t recognize anyone, and is curled up in a fetal position, with bedsores. All this has led to devaluing or ignoring the experience of being a patient by the medical organizations overseeing, and the individuals practicing, the DFMP system.

While there are many bright, caring and dedicated doctors today practicing a high level of medicinal care, unfortunately there are many examples of suboptimal care that patients and physician can site. Here are two examples.

Imagine a patient diagnosed with multiple sclerosis, struggling to accept her diagnosis, and a neurologist determined to convince her that she has MS by showing her pictures of the abnormalities on her brain MRI. “You have MS. See these abnormalities,” he repeated again and again. My initial response was, “Look at all the healthy brain tissue! Other parts of the brain that are healthy may be able to take over areas involved with your MS, and the areas that are now abnormal may heal so that in the future, you may recover function in those areas.” Then I said, “He’s not a doctor. He’s a diseaseologist!”

In another case, a medical oncologist left a message on a patient’s answerphone about an oncogene test, sent away weeks earlier, which was to determine if chemotherapy was needed for her breast cancer. “The results of your oncogene test came back to the office yesterday. Call the office if you want to discuss it.” Several calls and several hours later, during which time the patient and her family feared the worst based on the tone and wording of the message, the oncologist called back with good results. Think how differently this would have unfolded if he had left a message saying, “Good news” before he left the rest of his message?

Is there no hope? While recognizing that non-medical and societal factors may account for some of the bad outcomes and unhappiness in medical care today, some is directly related to the limitations of DFMP and to relying only on the DFMP paradigm in conceptualizing, organizing, administering, and paying for medical practice and healthcare.

What other healthcare practices are utilized today?

### **Life Force Focused Practice (LFFP)**

Today, LFFP systems of healthcare are usually called Complementary/Alternative Medicine (CAM). They are complementary and alternative to DFMP (Micozzi, 1996). The National Institute of Health has classified CAM practices into five categories. Included in these culturally different healthcare practices are systems thousands of years old – such as traditional Chinese Medicine (TCM) and Ayurveda (Indian Medicine), with practices including Acupuncture and Yoga. There are also more recent systems, such as Chiropractic and Homeopathy, to name but a few of the large and diverse group of LFFP systems. Every practice system has its own specific views of health and disease, health recovery and health maintenance. Even though experts in each tradition may use different words or disagree on fundamental concepts, there are yet some characteristics in common. Some core concepts shared among various LFFP systems and practitioners are their views of health and healing, including focusing on wellness, bioenergy, nutrition and natural products, plants, individuality (whole person orientation), and especially self-healing and how to enhance it. The term Life Force is used to include TCM's "Qi" or "Chi", Ayurveda's "Prana", Chiropractic's "Innate" or "Universal Intelligence" and Homeopathy's "spiritual vital force", among others (Micozzi, 1996).

To explore this further, we can use TCM as an example. Like many LFFP systems, TCM employs several treatment modalities, such as acupuncture, acupressure, Qigong (simple body movements to enhance Qi), herbal therapy, foods for healing, and Chinese Psychology. The basic assumption in TCM is that the body is motivated by self-healing energy/substance and the purpose of all practices is to promote wholeness through its flow, balance and harmony. For example, acupuncture or acupressure (e.g. shiatsu) attempts to remove blockages or stagnation, and to tonify depletions of Qi; it is the balance, harmony and flow that lead to good health. Disease results from imbalance, lack of harmony, or stagnation of Qi. The Chinese describe Qi as energy turning into matter and matter turning into energy; as energy plus intention. Healing depends on the connection between the healer and the healee – through the practitioner's knowledge, technique and intention and the patient's openness. For example, the same maneuver used successfully in shiatsu to heal a patient can also be used successfully in martial arts to subdue an opponent; the only difference is the intention of the user. Likewise, the openness of the recipient plays a role in the outcome. The diagnostic and therapeutic processes are not separate, but occur simultaneously. True healing in TCM involves the restoration of balance and harmony – strengthening the connection among all of the parts of the body – including the connection of body with emotions, heart, mind and spirit; of the connection of the individual with others (relationships); and of the individual's connection to the healing power of nature and the universe (Micozzi, 1996).

For example, Nan Lu, the renowned practitioner and teacher of TCM, describes four stages of disease progression in the development of breast cancer. In Stage I, imbalances and disharmonies in the energetic system appear, there may or may not be vague symptoms, and biomedical tests may be normal. At this stage, a TCM practitioner could diagnose and treat energetic system imbalances, such as Qi deficiency or stagnation. If this was not diagnosed and treated and progressed to Stage II, there would now be dysfunction of organs and organ systems accompanied by mild to moderate symptoms, although biomedical tests would again be normal. If this progressed to Stage III, a significant physical problem would be present that would be evident in biomedical tests. Stage IV is breast cancer. Thus,

with TCM recognizing and treating problems at an earlier stage, where biomedical tests may be normal, the progression to biomedical disease can be prevented.

The ideas and approaches of LFFP can sound foreign to anyone whose medical thinking is based only on DFMP. Both the poetic language and images of TCM and the reasoning and implications of quantum and electromagnetic physics may sound strange and “unscientific” to most modern physicians. Yet, surgeons depend on the body’s self-healing energy to heal the incisions that they make; sutures simply hold the tissues together while the body heals itself.

Isn’t it interesting that if all the matter in the human body were collapsed together, the resulting volume would be less than a grain of sand. If the same thing happened to the earth, it would be only a few feet across. The rest is energetic vibrations and interactions (Rutherford, 1908). Werner Heisenberg proposed that the quantum world consists of two phenomena – actualities and potentialities. Thus, we consist of very little matter, but much potential.

It is recognized in many areas of medicine that placebos (inert substances or unproven treatments given as a medicine or treatment or its suggestive effect) have great power. A significant percent of patients may improve with placebos, although a smaller percent may get worse (there can also be a negative placebo response). Evidence-based medicine, through randomized, controlled, prospective and double-blinded studies, may include a placebo control group to see if the effect of the particular drug or procedure is any greater than the effect of the placebo. Healthcare practitioners have long used placebos, including pills with inert ingredients or whose ingredients cannot produce a curative effect on the problems being addressed (such as B12 injections for fatigue, etc.).

Words have always had tremendous power: on the one hand they can harm; on the other hand they can diminish and remove fear and anxiety and give hope and encouragement. Like other forms of LFFP, which involve the good intent of the practitioner and the openness of the patient, the placebo effect and response relies on the patient’s belief system and can still be used today, especially if the patient is resistant to CAM/LFFP therapies (Spiro, 1998).

In the hierarchy of DFMP, the power is with the practitioner and the patient is passive; in LFFP, the power (self-healing energy) is in the patient, and the role of the practitioner is to communicate with that energy and to help the patient in making healing changes. DFMP often focuses on identifying the basic disease process, with the practitioner attempting to alter it with powerful medicines or surgery; LFFP, as exemplified by TCM, focuses on Qi stagnation and imbalance, restoring it not only through what the practitioner does, but also through what the individual person does by making changes in their everyday activities (diet, movement, breathing, sleep, relationships and spiritual practices). Thus, the practitioner is also a teacher, instructing the patient in self-care. DFMP splits the mind from the body, and its understandings and treatments are based on reductionism, while LFFP believes in unity: connections and communication amongst the body, emotions, mind, spirit, family, friends, work and the universe (Micozzi, 1996), and has developed its understandings and treatments based on the combination of all of these factors.

In addition, in LFFP, the presence of the practitioner is acknowledged as of primary importance. Practitioners are encouraged to work on themselves – to “clear the vessel through which healing flows”. When practitioners know from their own experiences what the therapies can do to heal, they become much more effective healers (Micozzi, 1996). By comparison, the recommended preparation for DFMP doctors is the acquiring of factual information and approaches by reading and conferences. While DFMP focuses (appropriately) on maintaining boundaries between doctors and patients, often to the point of prohibiting any physical contact with the patient other than one that is done during a physical examination, LFFP teaches to understand the appropriate type of connection (physical and otherwise) between the practitioner and the patient and utilizes it as part of a healing connection.

Whenever an observation or experience of LFFP cannot be explained and studied by Newtonian physics, or studied by randomized, controlled, prospective, double-blinded experiments, some conclude that LFFP is “unscientific.” Why should our method of proof of truth trump our observations? Isn’t that what the Roman Catholic Church did with Galileo? This unrealistic expectation is humorously illustrated by the story of a conversation between a drunk – on his knees, on the pavement, under a lamp pole, at 2 AM – and a policeman. “What are you doing down there?” “I’m looking for my watch.” “Where did you have it last?” “Two blocks away.” “Why aren’t you looking there?” “The light is better here.” Newtonian physics and its proofs should not limit our understanding and practice.

Unlike Newtonian physics and randomized, controlled, prospective, double-blinded studies, quantum and electromagnetic physics has developed theories to understand subatomic phenomena. Niels Bohr’s theory of complementarity proposed that particles in microscopic systems behave either as waves or particles (Bohr, 1922). Einstein postulated that  $E=mc^2$ . Not only does Quantum and Electromagnetic Physics extend Newtonian study to subatomic particles, it also studies connections and causalities not explained by Newtonian physics.

For instance, quantum mechanical equations show that two particles, once they have interacted, are instantaneously connected, even across great distances. These were initially stated as part of the Copenhagen interpretation of quantum mechanics and proved by experiments in the 1980’s and 1990’s. The scientific basis of LFFP is well documented by holistic psychiatrist Daniel Benor in his critical, multivolume work on Healing Research, containing nearly 2000 pages and over 4000 references (Benor, 2004; 2008). As stated by Marc Micozzi: “If biomedicine cannot explain scientific observation... then the biomedical paradigm will need to be revised” (Micozzi, 1996).

Quantum and electromagnetic physics can help to explain the scientific basis of many aspects of LFFP, as well as to explain the following three examples of entrainment, which were unexplainable phenomena under Newtonian physics: The first is the mutual phase-locking of two or more oscillators. Place pendulum clocks beating out of synchrony with each other in the same room and soon they are all beating in synchrony. Second, when two individual heart muscle cells are observed under a microscope, each contracts with its own separate rhythm, until they are moved closer together, when they all contract in perfect synchrony. Third, soon after women whose menstrual cycles start on different days of the month begin living together in a college dormitory, many of them have their periods starting the same day of the month (Leonard, 1978).

In reality, when DFMP refers to practices of LFFP as “unscientific” because they may not be amenable to Newtonian proofs, they really are a century behind in their definition of “scientific”, ignoring the scientific field of quantum and electromagnetic physics of the last century.

Taking nothing away from the scientific advances of DFMP, what are the areas where LFFP can improve health? LFFP stresses the importance of daily activities (breathing, eating, sleeping, movement, relationships, etc.) in achieving and maintaining good health and in disease prevention. This can lessen the burden (financial and otherwise) placed on a healthcare system spending most of its resources diagnosing and treating disease. Disease treatment can often be improved by techniques like acupuncture, by using several compounds acting *synergistically* (as in burns) rather than focusing on a single agent (“magic bullet”), and by complementing reductionism, with connectedness. Large numbers of people utilize LFFP, since it focuses on wellness, energy and disease prevention; since its treatments, when used for appropriate indications, frequently have fewer side effects and almost never has fatalities; since it understands the importance of relationships in the healthcare process; and since it may offer alternatives to patients who refuse to take hopelessness as an answer to their most urgent question of “What can I do for this problem I’m struggling with?” (Micozzi, 1996).

However, beware the practitioner of LFFP who views all DFMP practices negatively, discouraging patients from benefiting from medications or surgery. One of my patients sought out an MD expert in Yoga to help her with her severe arthritic pain. Unfortunately, he also told her to stop a non-steroid anti-inflammatory medicine (NSAID) that had given her significant pain relief and had dramatically increased her ability to get around, because “it would burn a hole in your stomach.” This practitioner made two mistakes: first, that specific NSAID medicine was one of the least irritative to the stomach (as demonstrated in scientific studies); and second, using fear tactics has no place in any healthcare system, because it adversely affects the healing process, especially when people are sick and more vulnerable. Any practitioner who truly understands LFFP would recognize and respect that.

Before sharing an example of dealing positively with fear, let me share some historical, medical information. You may be familiar with the term cholecystectomy, which is the removal of the gall bladder. Before surgeons were able to do it through small holes (called laparoscopic cholecystectomy) placing less stress on the body during the surgery and in the healing afterwards, if the patient was too sick, rather than put them through the serious operation of open cholecystectomy (in which a large incision was made in the abdomen), they would just put a tube in the gall bladder and drain it, called a cholecystotomy.

The personal example that I tell my patients at times is that the only operation that I do is a fearotomy, not a fearectomy, because I cannot remove fear if people want to hold onto it. I can only provide my patient with all that they will need to get rid of their fear, if they want to.

### **Patient Focused Medical Practice (PFMP)**

Historically, it is PFMP and not DFMP that can trace its origin back to Hippocrates (460-377 BCE), whose school is credited with being one of the originators of medical practice. As described earlier, four centuries ago PFMP was displaced by DFMP. A return to studying PFMP began with the work of James MacKenzie (1853-1925) exploring patients’ feelings and what Sydenham (as mentioned above) called the idiosyncratic, non-pathognomonic or atypical part of the history (Reiser, 1978). MacKenzie found that patients’ reports of feelings often produced the earliest clue for the presence of disease, often before objective biomedical test results.

Others added that attentive listening could illuminate the emotional and social components of patients’ complaints, thereby improving the effectiveness with which their illness was managed. Michael Balint (1896-1970), in his work with general practitioners, discovered that the most frequently used drug in general practice was the doctor himself/herself, and went on to study the dynamics of *The Doctor, His Patient and The Illness* (Balint, 1964). George Engel (1913-1999) coined the term biopsychosocial medicine and developed a program in psychosomatic medicine at the University of Rochester, recognizing and teaching the influence of psychological and social factors in both illness causation and in managing its effects on patients (Engel, 1977). In subsequent years, the role of spirituality and religion in many patients’ lives, including illness, has been recognized, leading to the term biopsychosocialspiritual medicine. Current research shows that the body and mind are one, and that the human body is more than a structure and biochemical entity. Psychoneuroimmunology research has established that thoughts, feelings, emotions and perceptions can indeed affect the body. For instance, research and experience has shown that heart attacks are sometimes preceded by depression.

Ian McWhinney (1926 - 2012) coined the term Patient Centered Medicine (PCM) (McWhinney, 1998). Elements of PCM may be millennia old in practice, but it was initially described and championed by those from the Center for Studies in Family Medicine at the University of Western Ontario, Canada (Stewart, 2003). They described six interactive components of the patient-centered process: (1)



exploring both the disease and the illness experience; (2) understanding the whole person and his/her community; (3) finding common ground on what the problem is and mutually agreeing on management; (4) incorporating prevention and health promotion; (5) enhancing the continuing relationship between the patient and the doctor; (6) being realistic (not everything can be achieved at every visit). PCM should also explore the patient's main reason for the visit, examine the patient's concerns and need for information, and seek an integrated understanding of the patient's world – their whole person, emotional needs and life issues. All of this can lead to individualized, empathetic care. By sharing power between the patient and the doctor, the patient is empowered (greater understanding, participation, etc.), as is the doctor, who becomes not only the diagnostician for diseases but also the carer for patients (Stewart, 2003). Connecting with the patient mindfully, with compassionate awareness, may lead to understanding the conditions experienced by the patient and also provide guidance to what treatments may best work for the specific patient.

There are misconceptions about PCM. Some of the more common ones include that it takes more time; it focuses primarily on the patient's psychosocial issues rather than the disease; it requires acquiescing to the patient's demands; it means seeking out the patient's "hidden agenda"; and it expects sharing all information and all decisions with the patient. These are exaggerations of its practice and goals (Stewart, 2003). PCM does not mean that the physician must give up what she/he feels needs to be accomplished in the visit to help the patient. Patient centered means that the patient is at the center of the visit; it is the attentive listening and compassion practiced by, and the knowledge possessed by, the physician that can lead to the best possible healthcare.

Recently, primary care organizations have coined the term "Patient Centered Medical Home", where medical care is physician-directed with a personal physician, has whole person orientations, is coordinated and integrated, and includes attention to quality, safety, enhanced access to care, and level of payment.

For decades, payment models have been based on the diseases present rather than what the physician is doing to improve the patient's conditions. New payment models for primary care can save considerable amounts of money. Gorroll describes it as "comprehensive pay for comprehensive work". For example, Milstein's Ambulatory Intensive Care Unit, which targeted the 20% of patients who utilize 60% of the following years' resources, ran operating costs of 2.7 times the typical primary care clinic and yet resulted in a net savings of 36.9%.

Long-overdue improvements in reimbursement for PFMP should include improvements in medical practice, including utilizing approaches and skills (including, but not limited to) in which the physician is an expert diagnostician and clinician, patient advocate, good communicator, team leader and effective teammate, systems manager, knowledgeable user of health information technology and health data, a change agent, and accountable for efficient, accessible care (Barron, 2008).

Another important aspect of PFMP is mindful practice, as described by Ronald Epstein (Epstein, 1999). In the words of Anais Nin, we don't see things as they are, we see things as we are. Utilizing mindful practice, practitioners non-judgmentally monitor their own physical and mental processes and their emotional and spiritual states. This self-observation and reflection also brings into consciousness tacit knowledge, learned through studies and by observation and practice, and used by seasoned practitioners. The insights from this self-awareness allows the practitioner to recognize their own strengths (values, belief systems, theories-in-action) and weaknesses (blind spots, biases). Greater understanding of self allows for greater understanding of patients, greater comfort in their presence and more attentive listening – enabling the practitioner to respond with empathy and compassion. The open mindedness, flexibility, humility and curiosity liberated and deepened by mindful practice can complement evidence-based medicine and expert opinions. This combination of self-observation with attentive listening to patients is similar to what good musicians do: performing themselves, while at

the same time listening to what they are playing, listening to what others are playing, and also focusing on the technical, emotional and structural aspect of the piece. Although this may sound complicated, mindfulness is attending to the ordinary, the obvious, and the present. Johann Sebastian Bach is reported to have said, when asked how he found melodies: “The problem is not finding them, it’s – when getting up in the morning and out of bed – not stepping on them.” Continuing with the musical analogy, a picture of a violin that hangs in my office includes the words “Music is in all our hearts, and if we listen closely, we will hear each other’s song.”

Larry LeShan refers to two goals of a practitioner: first, the relief of symptoms by using techniques - in which the practitioner is similar to a mechanic; and second, setting up the ecological environment allowing the patient to thrive, which involves the recognition of, and respect for, the individuality of the patient, in which the practitioner is similar to a gardener. Modeling of several types can achieve this second goal. By listening to the patient, the patient will listen to themselves; by respecting the patient, the patient will respect themselves; by caring for the patient, the patient will care for themselves; and by having hopes for the patient, the patient will have hopes for themselves. And as importantly, patients will be more likely to follow what they are told if practitioners themselves model what they preach.

Stephen Post writes about and teaches Compassionate Care Enhancement. It is interesting that the word compassionate comes from the Latin root ‘pati,’ meaning suffering. Suffering, and the distinction between it and pain, were well described by Eric Cassel (Cassel, 1982) . Ideal doctoring can be said to combine understanding, diagnosing and treating diseases, while appreciating and caring for the uniqueness of each patient – both their suffering (whether from illnesses or from other causes) and their life force, with its ability to respond to stresses (illnesses and otherwise).

In summary, here are some of my favorite, memorable insights and sayings about ideal doctoring.

The importance of what doctors say and how they say it is captured independently by Philip Tumulty and Stanley Reiser: “What the scalpel is to the surgeon, words are to the clinician.”

Narrative medicine, a valuable practice technique, has been championed by Rita Charon: “Along with scientific ability, physicians need the ability to listen to the narratives of the patient [the story and the plights], grasp and honor their meanings, and be moved to act on the patient’s behalf.”

Dennis Novack’s list of affective therapeutic strategies include empathy, encouraging emotional expression, encouragement, offering hope, touch, facilitation of self-forgiveness, and reassurance.

Insights into what doctors may receive from their caregiving come from Michael Daley: “As the caregiver attends the carereceiver, plying whatever arts and sciences the situation demands, while the carereceiver become better in terms of returning to health, the caregiver gets better in terms of deepening interiority or moral health.”

The importance of both competence and caring is captured by Al Ureles: “Knowledge without compassion in our profession is an obscenity, just as compassion without knowledge in our profession is quackery.”

Albert Schweitzer understood the art and science of medicine: “It is our duty to remember that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient.”

Another beautiful quote from Albert Schweitzer guides my care about and for patients: “The witch doctor succeeds for the same reason all the rest of us succeed. Each patient carries his own doctor

inside himself. They come to us not knowing that truth. We are best when we give the doctor who reside within each patient a chance to go to work.”

What it means to be a physician is described by Leon Kass, “If a doctor would be a physician and not merely a body technician, he must also be a knower of souls, those of his patient and, not least, his own.”

Perhaps the most famous quote about medical care come from Francis Peabody, When he compared the impersonality of treating diseases with the very personal care of treating patients, he said “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”

Lastly, a non-medical person, a high school mathematics teacher originally, Sam Levinson said that God gave us two ears and one mouth, to listen more and speak less.

## **In Conclusion**

In Part 1 of this article, we have considered three different and valid models of healthcare: Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP) and Patient Focused Medical Practice (PFMP). Each has its benefits as a healthcare approach. In Part 2, we will discuss how to implement these models to achieve the best possible healthcare.

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