THE INTERNATIONAL JOURNAL IJHC OF HEALING AND CARING

The International Journal of Healing and Caring

WHOLISTIC HEALING WHP PUBLICATIONS

May, 2017 **Volume 17, No. 2**

The Best Possible Healthcare, Part 2

By Ronald S. Banner, MD

Abstract

The Best Possible Healthcare requires fully functioning physicians. Today, over 50% of practicing physicians suffer from burnout, a syndrome of exhaustion, cynicism, and decreased effectiveness at work. Twice as many additional hours are spent by physicians for record keeping as are spent in direct clinical care. Today, physicians look at computer screens, not their patients. The regulation of medical care today in the U.S. is based on the Disease Focused Medical Care Model, focusing on the disease the patient has and not the patient who has the disease, substituting measurements of diseases and treatments instead of caring for patients and their experiences. To return the focus of healthcare to patients requires using all three models of patient care: Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP). Patient Focused Medical Practice (PFMP), discussed in Part 1 of this paper and amplified here in Part 2.

Key words: Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP). Patient Focused Medical Practice (PFMP), patient-centered medicine, burnout

Brief summary of the serious problems in healthcare

The Best Possible Healthcare requires fully functioning physicians. Today, over 50% of practicing physicians suffer from burnout (Shanafelt, 2017), a syndrome of exhaustion, cynicism, and decreased effectiveness at work. “For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent doing… computer and other clerical work (Sinsky, 2016).” “The current burden of documentation… (required) is unsustainable (Shanafelt, 2017).” Today, physicians look at computer screens, not their patients. This is because the regulation of medical care today in the U.S. is based on the Disease Focused Medical Care Model, which focuses on the disease the patient has and not the patient who has the disease, substituting computer measurements of diseases and treatments instead of caring for patients and their experiences. To return the focus of healthcare to patients requires using all three models of patient care, Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP). Patient Focused Medical Practice (PFMP), discussed in Part 1 of this paper and amplified here in Part 2.

How to achieve the best possible health care

My thesis is that the best possible healthcare requires practitioners to utilize the concepts and approaches of all three types of practice systems in their care of patients: Disease Focused Medical Practice (DFMP), Life Force Focused Practice (LFFP) and Patient Focused Medical Practice (PFMP). This does not mean that every doctor must be competent in all the techniques of all three systems, to be able to perform cardiac catheterization and acupuncture; to prescribe medical drugs and homeopathy; to be skilled in addressing physical trauma and equally skilled in helping patients develop the awareness to do the introspections that can uncover the contributions of their thoughts, emotions, and relationships to their symptoms and illnesses. It does require of the doctor competence in diagnosing and treating their patients' diseases; it does require an awareness of, and respect for, their patients' life force; it does require caring for their patients, utilizing insights and approaches of PFMP.

Although some patients may not feel the need for all three practices in every encounter with the healthcare system, and although the doctor may not need to use approaches from all three practice systems for every patient at every visit, the doctor still needs to be sufficiently versed in understanding these three practice systems. While primary care practitioners will benefit most from utilizing the concepts of all three practice systems, medical specialists and alternative care practitioners can also benefit from this approach.

For example, when my appendix ruptured, the diagnostic and therapeutic competency of the surgeon may have been the most important thing. However, by his using PFMP approaches also and allowing me to see a physical therapist to regain my strength and to speed my recovery, I also learned about an abdominal binder, which reduced the pain when I moved. LFFP also contributed: seeing a hypnotist on the second post-operative day reduced my pain and the need for narcotics; listening to Mozart piano sonatas during my hospital stay helped put the emphasis on enhancing my healing, not only on diminishing my discomfort.

Accepting this thesis requires a mind shift in most practitioners who have been taught to see healthcare only from the perspective of the model they have learned and practiced. They may only think "inside the box". To "think outside the box" and understand the validity and usefulness of other practices requires education and openness. In addition to learning factual information and a better theoretical understanding of each practice, there also needs to be *experiential* education, leading to a deeper appreciation of each practice's value in patient care.

For medical doctors (MDs and DOs) and other healthcare professionals in the DFMP system this has already begun, with some of their education including subjects of CAM. However, to truly achieve the necessary mind shifts, such education must do more than present a technique like acupuncture, with a DFMP-type list of symptoms followed by which acupoints to use for each symptom.

Both patients and doctors may feel frustrated that there is no cookbook approach, which matches specific symptoms with specific LFFP systems or techniques. For acupuncture to be truly understood and accepted (when to use it, how to interact and discuss patients with an acupuncturist, etc.), educational offerings must also teach how LFFP thinks about health and disease and that acupuncture is but one component of Traditional Chinese Medicine. Education must also address the stigmas attributed to LFFP and DFMP based on "horror stories," stories where something horrible is ascribed to a DFMP treatment or a LFFP treatment. Why not allow medical doctors to experience relief of symptoms by experiencing acupuncture (or other LFFP modalities) themselves? Indeed, practitioners in all three practice systems should also receive education in the systems that they do not practice and in which they have not been educated. This facilitates appropriate referrals and a patient-centered team approach.

What will motivate doctors to make the needed mind shift? Today, because medical care and its payment is largely based on the paradigms of DFMP with its depersonalization, physicians often find their work unsatisfying. As described by Rachel Remen, meaning is the antecedent of commitment and service . Combining the approaches and thinking of all three practice systems may help physicians regain meaning – a human need, reminding us of who we are and what we stand for in our work and lives (Remen, 2009). Our interactions with our patients should enhance, not diminish, our life force.

The educational process will have greater initial impact with some healthcare practitioners (than with others) who will become the pioneers in moving this process along. What may characterize those more open to learn and accept? During my years of medical practice, I have been blessed to connect with, and learn from, practitioners of DFMP, LFFP and PFMP. Based on those interactions, I feel that those practitioners who will be more open to learning about, and accepting, what I am suggesting may be more secure and less threatened, having learned from experiences with their patients and with others, as well as from their training. Also, they may see this new growth as a welcome and interesting challenge rather than as a threat. They may have both enough self-esteem and humility to recognize that, in their search for knowledge and understanding, the beginning of wisdom may be confusion and they are open to the challenges in this exciting journey. They may have curiosity in this new adventure. While they take their work seriously, they may be secure, humble, have a sense of humor, and take themselves lightly. Lastly, they may have a desire to connect with practitioners of other healthcare practice systems, to build bridges of understanding and caring, and to enhance their patients' healthcare.

If one of these three practice systems by itself could help every patient get better all the time, the other two practice systems would become extinct. If one of the LFFP systems by itself could help every person get better all the time, the other LFFP systems would become extinct. That is not the reality. We can learn important lessons from the story of the blind men and the elephant. Each blind man feels a different part of the elephant's body and tries to identify what he is feeling. The one feeling the tail thinks it is a snake, the one feeling the ear thinks it is a fan, the one feeling the leg thinks that it is a tree. Only if these blind men communicate, share their observations, and use their imaginations can they learn that it is an elephant.

This increased understanding and acceptance of all three healthcare practice systems can have profound and restorative effects on the structure of medicine. In my opinion, PFMP would serve well in a central role in healthcare because MDs and (in the US) DOs are trained in medical diagnosis and can follow and know their patients over many years. PFMP doctors should not be viewed simply as gatekeepers, keeping their patients away from expensive technology, or as assembly line workers following the proper guidelines for their patients' conditions, but as having a central and essential role in patient care. Patients' initial contact with the healthcare system should ideally be with fully educated PFMP practitioners, unless an emergency requires immediate evaluation and intervention by a DFMP doctor, or there is a condition which has been treated successfully in the past by a LFFP practitioner.

PFMP doctors will be able to better respond to all their patients' needs by going beyond DFMP, by using the biopsychosocialspiritual framework for diagnosis and management, by seeing the patient as a whole person, by understanding, valuing and employing the doctor-patient relationship, by practicing mindfully, and using attentive and compassionate listening.

Patients will also be pleased with the emphasis on accessibility, comprehensiveness, coordination, and continuity that are inherent in PFMP.

Placing PFMP doctors in this central role will also increase their responsibilities. While they have been trained in DFMP, they must now become expert in PFMP. As in learning about LFFP, this will require factual and experiential learning about PFMP, leading to a shift in their "mindset", which in turn will lead to a change in their practices. PFMP doctors must still think about the diseases affecting their patients and must continue their education about diseases and their treatments. This will enable PFMP doctors to treat their patients' diseases and to know when to refer their patients to specialists and how to discuss their patients with specialists. In addition, PFMP (and indeed DFMP) practitioners must respect, and be in awe of, their patients' life force and how it impacts their care, and become knowledgeable enough about LFFP to know when to refer their patients to practitioners of LFFP, and how to talk to them about their patients. Only by understanding the language of, the thinking behind, and the value of each practice system can PFMP doctors appropriately utilize all systems in caring for their patients, and in conversing with other practitioners to coordinate their patients' care.

Today, doctors often rely on guidelines based on evidence-based medicine. However, seasoned practitioners also rely on their clinical judgment, learn from both their own experiences and those of their patients'. For example, what are some of the questions that should be asked in the diagnostic process? How serious might the underlying disease process be and how rapidly is it moving? A new, "minor" symptom, such as recurrent chest symptoms only on making the bed, may require urgent exercise stress-testing or cardiac catheterization.

At the other extreme are conditions where the use of a period of time for observation, with minimal or no interventions, may be the best diagnostic approach, waiting to see if the symptoms resolve entirely and never return. While some patients may feel more secure having a test done to give a name for their symptoms, others may be more anxious having to take time from their schedule to go through testing and then having to make sense of the findings. Whenever possible, using time as a test is prudent, because many medical interventions can have negative effects. Even though this is just a small percent of those who have the interventions, it is a caution worth considering when statistics show that conventional medicine is the fourth leading cause of death. Reported deaths due to medications that are properly prescribed and used have been slightly above 100,000 per year since 1998. Another 150,000 reported deaths annually have been attributed to medical errors (Starfield, 2000).

What other questions should be asked in caring for patients? . When should non-invasive tests be used (often less specific in making a diagnosis) and when should invasive tests be used (often more accurate, but also often with more potential for harm)? How will test results alter treatment and/or could they have a beneficial or detrimental effect on the patient? What should be done with unrelated findings uncovered in the process of ruling out disease and how will this affect the patient? Questions like these and others should be asked before any diagnostic or therapeutic venture is undertaken - if we truly value the core principle of "Do no harm."

Just as the acceptance of hospice by insurance payers was based partly on the money saved compared to costs with aggressive care/chemotherapy/ICU's, insurance carriers could also save money by accepting the PFMP model. When complicated evaluation of all of the human factors involved in illness requires extended time, it should be reimbursed adequately, basing it on understanding the components of PFMP and not simply basing it on components with DFMP. These evaluations can lead to a fuller understanding of the patient's illness, to a more comprehensive plan to manage it, and to better outcomes. Interestingly, this increased reimbursement to PFMP doctors (for the increased time associated with enhanced patient evaluation and management) may actually save money, by decreasing expensive testing and referrals to specialists. Specialists need not worry,

because they still will be very busy and in great demand, but the long waiting time associated with seeing them could be shortened.

By utilizing LFFP where it can effectively treat illnesses,, there will be less need in many cases for the most expensive components in healthcare today leading to further financial savings. For instance, in an appropriate situation, if a LFFP practitioner can effectively treat a patient's condition without getting an MRI, money will be saved and the symptoms will be relieved (which an MRI cannot do). Matching the patient and their symptoms with the appropriate practitioner can produce better outcomes, may lead to healthier, happier patients, and to financial savings, as well. For example, if a patient with continuing shoulder pain that does not have any of the "red flags" of serious illness that must be acted on promptly by a DFMP specialist were to see a competent massage therapist for treatment by the therapist, and also for recommendations for self-treatments to be done by the patient, the patient's symptoms may be relieved and the cost would be far less than obtaining an MRI of the shoulder (and the MRI would not relieve the patient's symptoms). In addition, by encouraging healthy daily activities, LFFP may reduce the symptoms and conditions for which patients need to be treated. I also find that it is important, when treating a patient for a specific problem, to inquire about what was happening in the patient's life around the time that they "got sick." A prolonged bronchitis occurring around the anniversary of a loved one's death may respond quicker once the loss is recognized and dealt with.

This also has implications for today's medical-legal crisis, and for the growing recognition of mistakes in patient care today. Mistakes often occur because of the lack of continuity, coordination and communication – values inherent in PFMP. Comprehensive evaluation of patients' symptoms rather than practicing defensive medicine should lead to more appropriate patient treatment, healthier and happier patients, and fewer malpractice suits. In addition, utilizing the PFMP approach, more sensitive to the person who has the illness, in addition to the DFMD approach, should reduce anger in patients, leading to a decrease in lawsuits. As a practical example of the needed coordination between DFMP practitioners (hospitalists) and PFMP practitioners (Primary Care Physicians), when patients are discharged from the hospital, a copy of the discharge summary should always be sent (emailed or faxed) to the Primary Care Physician, so that they can follow up on issues identified while in the hospital. Today, the only information frequently sent are a list of medications and informational sheets given to the patient (You Have Chest Pain) – which is not what the PFMP doctor needs in their follow-up evaluations of the hospitalization and in implementing changes based on what was discovered during the hospitalization.

In summary

Although DFMP, LFFP and PFMP have been presented as three distinct types of healthcare practices, practitioners often use approaches of more than one system. The best possible healthcare often requires combining elements of each practice system in approaching individual patients and situations. Historically, William Olser, the greatest internist of his time, was more than only a DFMP doctor. The concept of yin and yang from TCM is germane. The yang side of a mountain is the side on which the sun shines; the sun does not shine on the yin side. One is not good nor the other bad; both are needed for the mountain to exist. Likewise, reductionism and connectionism compliment each other, as do matter and energy, body and mind-spirit, right and left brain functions, to name a few of the approaches needed to achieve the best possible healthcare.

Understanding the three healthcare practice systems and their implications can begin today, with individuals and institutions seeking to learn how this can improve healthcare. It is my hope that this article will stimulate patients and doctors to want to learn more by reading about, and talking to, others familiar with these ideas and to seek out caring practitioners competent in these approaches – to improve the healthcare of individual patients. Another worthwhile goal might be for a group - composed

of practitioners on the micro level, of insurers and institutions at the macro level, and of patients - to talk, learn and plan together and to discuss, and implement, this new paradigm of care. American healthcare is now undergoing drastic changes in the character of its delivery system, thus making it an appropriate time to consider altering the nature of its conceptual system.

References

Remen, R.N. (2009). Recapturing the Soul of Medicine. Speaking of Faith from American Public Media publicradio.org.

Shanafelt, T.D. (2017). Addressing Physician Burnout. JAMA, 317 (9): 901-902.

Sinsky, C. (2016). Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Annals of Internal Medicine 165 (11) 753-760.

Starfield, B. (2000). Is US health really the best in the world? Journal of the American Medical Association, 284(4), 483-485.

Ron Banner, MD is grateful for the many blessings during his medical journey in Philadelphia: for recognizing, on entering practice, that his residency had not prepared him adequately, leading to the study of psychosomatics (mind-body interaction); for being asked to participate in founding a Hospice, a study group and program in Medical Ethics, and a program in Pastoral Care; for lessons from a physical pain in his neck, introducing him to Shiatsu, leading to learning about Traditional Chinese Medicine; for over 40 years of the calling of practicing General Internal Medicine (mostly solo) with wonderful Patients, staff and colleagues; for the Teachers, including patients, encountered during those years, and for his wonderful family and friends who walked with, and shaped him during his journey.

Contact details:

2050 Welsh Road, Philadelphia, PA
ronbannermd@yahoo.com