

Unnecessary Health Care System Ineffectiveness

Nature, Cause and Solutions

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Unnecessary Health Care System Ineffectiveness: Nature, Cause and Solutions

The Index below is provided to give an overview of the topics presented herein. Please note that each section builds upon information presented and substantiated in previous sections, such that a full understanding of the composition will not be acquired unless all sections are read sequentially.

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PART 1: PRELUDE - A STORY OF FAILURE

Re My Physical Health Challenges

I first became clinically ill 25 years ago. My health decline has been progressive and I still have not received a conclusive diagnosis. Through referrals from my Primary Care Providers, over this time I have seen (sometimes multiple) Gastroenterologists, Rheumatologists, Internists, Allergy Specialists, Dermatologists, Infections Specialists, Surgeons, Chiropractors, Neurologists, Psychiatrists, and Heart Specialists (as well as Psychologists and Physiotherapists for support in the struggle to cope with debilitating illness), and yet – not one of these Medical Professionals has even attempted to conduct the in-depth testing necessary to identify the underlying cause(s) of my ever growing symptom profile and ever growing list of abnormal test results. The number, range and severity of symptoms has been slowly progressive over 25 years, and now approach a level of complete debilitation.

Re My Mental Health Challenges

Approximately 10 years after my physical symptoms commenced, I began to experience a decline in cognitive function and memory, as well as experiencing low level chronic depression. I went to the MJ Mental Health Unit during the 90's to address these problems, at which time my claims of declining function were denied, trivialized and dismissed.

In both the physical and mental health care systems, it appears that only acute problems with patients who are in crisis are acknowledged as bona-fide illness.

It took me 5 years of doing my own research with subsequent requests for specific tests (SPECT and MRI scans) that clearly showed neurological abnormalities, as well as in-depth psychological testing (which had to be repeated after a few years to demonstrate decline), before my problems and decline were taken seriously and acknowledged.

I consider this diagnosis and treatment failure to be unnecessary ineffectiveness. Without my own investigations into which particular tests were likely to objectively demonstrate that I was having problems, I may have never had my problems acknowledged at all (until and unless my underlying health problem had progressed to the point of causing mental crisis). This was five years of my life that I and my Caregivers could have spent investigating (and possibly addressing) the underlying physiological cause(s) of my mental (and physical) health problems - which likely share the same underlying cause or pathology.

Instead, my mental health symptoms had been second guessed, trivialized and dismissed for years before they were taken seriously and acknowledged. This forced me to waste years of energy and initiative focused on figuring out how to convince my Caregivers (in irrefutable medical terms) that I had a problem at all – so we could finally get started with diagnosis and treatment.

Even to date, there have been no in-depth investigations conducted to even try to identify the underlying metabolic or biochemical causes of these problems, by either physical or mental health Caregivers (in spite of my requests for them from every Specialist to which I have been referred). This illustrates a similar major failure that is common to both physical and mental health care systems.

PART 2: CAREGIVERS' ROLES AND PERCEPTIONS

In this section, I will relate the perceptions and practices of both physical and mental health Caregivers that lead to effective health care. Then I will contrast this by relating the common perceptions and practices of Caregivers that result in ineffective care – with particular regard to complex chronic medical problems.

a) Caregivers' Perceptions of Roles & Responsibility Instrumental to Treatment Effectiveness

It is the Care giver's responsibility to conduct (or orchestrate through referrals) whatever investigations are necessary to identify and conclusively diagnose the core root of each patient's health problems, and then provide treatment to achieve maximum possible recovery, to whatever degree that modern medical science and technology permits.

Until the underlying cause(s) is/are determined, this entails ever deeper and more thorough investigations of biochemistry and metabolism to determine potential causes of both symptoms and unusual test results, (as always - subject to the limitations of modern medical science).

A thorough and relentless investigation should be conducted without delay, before the initial core problem progresses to further deregulate metabolism and homeostasis, which will affect other physiological systems to create more symptoms and complicate whatever recovery to a normal healthy homeostasis that is possible. Diagnosis and treatment without delay will also minimize the chance of irreversible damage to any organ or system, (and of course, to restore the patient's quality of life as much as possible, as soon as possible).

When there is more than one approach available to such investigations and treatment, all approaches will be utilized if necessary (either sequentially or concurrently) in an order starting with the approach considered most viable to secure maximum recovery, until all (scientific and potentially viable) approaches are exhausted, until recovery is secured (or, until unaddressable causes are conclusively identified).

The treatment of symptoms is never accepted as treatment success or effectiveness, unless all viable approaches to real recovery have been exhausted, subject to the limitations of modern medical science and technology.

Every symptom and every abnormal lab test result should be analyzed as to possible cause(s), and considered a valuable clue to assemble the puzzle of “How and Why is normal metabolism deregulated?”. Most symptoms and most abnormal lab tests have multiple known causes (and perhaps some causes as yet unknown) – which may make it impossible to determine cause conclusively for a particular symptom or abnormal lab test result. But, it is when each and every symptom and abnormal lab test result is analyzed and investigated as to possible causes, that the common deregulated biochemistry or metabolic pathways of the core problem are most likely to reveal themselves (with all symptoms and abnormal test results reflecting the core root biochemical abnormality, either directly or indirectly). This is the (dying) art of Caregiver as a puzzle solving sleuth.

In complex or challenging medical problems, when a Caregiver does not possess the knowledge necessary to investigate a symptom or abnormal test result, or when their current approach has not been effective, they have a responsibility to do one of the following;

- A) Learn new viable approaches themselves (especially if such approaches are likely to help other patients they treat).
- B) Refer the patient to other Caregivers who already possess the expertise and initiative (and have a record of effectiveness) to utilize whatever approaches may be necessary to secure a conclusive diagnosis and the most effective treatment available.
 - When Caregivers utilize the expertise of other Caregivers, they will still oversee treatment to ensure conclusive diagnosis and effective treatment have been provided. When it is not secured, additional referrals will be made until it is secured, or option A may be revisited.
 - In complex cases, when referrals to more than one Specialized Caregiver may be required, the referring Caregiver will oversee, integrate and reconcile the findings and contributions of subsequent Specialists (or will ensure that at least one of the Specialists on “The Team” accepts and fulfills this responsibility). Referrals and investigations will continue as necessary until an understanding emerges of how all symptoms and abnormal test results relate to the core underlying cause(s) of the patient's health challenges (subject to the limitations of modern medical science and biochemistry). Caregivers can defer or delegate authority for a patient's care to other Caregivers/Specialists, but they cannot defer or delegate responsibility for it.

In summary, the above essentially states that it is every Caregivers responsibility to either diagnose and treat a patient effectively, or to refer them to another Caregiver who does, and then follow up to ensure effective treatment was provided (if such treatment exists).

A secondary but still important consideration, is that it is every Caregivers' responsibility to provide the most effective health care possible, within the least time possible - in order to minimize the total (long term) health care costs to the Patient, to the Health Care System, to Government, and to Society.

A Summarized Example of Effective Clinical Approach (to a complex chronic problem)

- Please give me a complete list of all of your symptoms (as well as relating your medical history, diet, lifestyle and any other information you feel may relate to your health problems, if this has not already been provided).
- We will do our best to determine the underlying problem(s) behind all of your symptoms, using whatever tests may be necessary to achieve that end.
- Unusual test results will provide further leads, and will also be analyzed as to cause. This may require several rounds of tests in ever greater depth of analysis of ever more specific biochemistry, before the cause is revealed (in biochemical or metabolic terms). If the local lab will not do the depth of testing that we require, we will utilize other labs that do.
- If I am unable to connect the symptoms and abnormal test results to a common cause(s) – to make a conclusive diagnosis and prescribe effective treatment, I will either learn what I must to do so, or else I will consult with and/or refer you to one or more additional Caregivers with the expertise and willingness to conduct further investigations on my behalf. But I will follow up to ensure that thorough investigations are being conducted without delay, and to reconcile and integrate the findings of all Specialist Caregivers that you will see, to solve the larger puzzle of your health challenges (to the limits that current science permits).

b) Caregivers' Perceptions of Roles & Responsibility Instrumental to Treatment Ineffectiveness

Job effectiveness is presumed to be the result of running through a set of prescribed, standard, conventional procedures, regardless of whether or not this results in conclusive answers or effective treatment. When the the standard prescribed (limited) approach to diagnosis and treatment has been applied, the job is done. If a patient with chronic health challenges still has symptoms and/or abnormal test results, it is acceptable to simply ignore or dismiss them. No further or more in-depth investigations are warranted. Next patient please.

As long as the above approach is utilized, every Caregiver is presumed to be doing the best they can, to provide the most effective Health Care available, and therefore is presumed to possess personal integrity, compassion, competence and professionalism that is not subject to question. Thus, we can conclude that you must be getting the best health care available.

The conventionally prescribed medical system and approach has no systemic boundaries or limitations in its provision of effective treatment, or at least none that are significant enough to warrant attention or action to rectify or eliminate such barriers, or to warrant approaches outside of convention by individual Caregivers. (Note: This implicitly assumes that the system prescribed conventional approach utilizes all of the best, most effective approaches available, and has kept pace and incorporated the latest breakthrough medical discoveries).

Ineffective treatment is the exception rather than the rule. (Implicit: This myth is to be maintained in spite of the elephant in the room - that virtually every person you speak with can convey one or more personal horror stories regarding themselves or a family member, that relates to unnecessary Health Care System ineffectiveness (often with tragic consequence). The trivializing “rare exception” myth also denies the very existence of people like me, who go for 5, 10, 20, 25 years or longer repeatedly requesting, but never receiving a thorough investigation or conclusive diagnosis of their problems - which of course eliminates any possibility of effective treatment).

Any perceptions/suggestions that the conventional approach to treatment has any limitations or barriers to effective treatment, should be trivialized and ignored, since we as Caregivers are powerless to do anything to change our system or our personal approach anyway.

Effective health care (achieved through undelayed thorough investigations as necessary to reach conclusive diagnosis and effective treatments, whenever possible) takes too much time and costs too much money, so we just have to accept ineffective health care. Implicit: This myth needs to be maintained and propagated to maintain the illusion that ineffective assembly line, recipe book health care (which keeps people ill and utilizing health care products and services indefinitely) actually costs less than thorough, effective, undelayed health care. This is not to mention the costs to Society due to unnecessary early debilitation. This myth also requires that we ignore the fact that Health Care costs also represent Health Care Industry revenues (which industry leaders have endeavored to maximize – with great success).

Treating symptoms is the same thing as treating health problems. Short term symptom suppression is considered success, even when the core root of the problem remains unidentified, unaddressed and progressive, and even when longer term toxic side effects of symptom suppressing drugs are probable and expected.

It is acceptable (and even considered professional) to second guess, dismiss, ignore or trivialize a patient or their symptoms if their health problems are complex, and not immediately understood after an initial cursory (standard conventional) evaluation.

When health challenges are not immediately understood, a dismissal on the grounds of mental pathology (with or without referral) is an accepted (and even promoted) alternative to further in-depth investigation, or taking the time to learn enough about a condition to be able to treat it effectively. Once a label indicative of a mental pathology has dismissed a patient, no further in-depth analysis of biochemistry is warranted to explain any abnormal test results or chronic symptoms (physical or mental), even though deregulated biochemistry underlies virtually every health problem (physical and mental), and potentially effective treatment lies in identifying and addressing the abnormal biochemistry that is responsible.

It is not a Caregiver's responsibility to learn about other approaches (that may potentially be more effective) than the approach that they are already familiar with (either within or outside the conventional practices/guidelines of their specialty). If they do not have a quick and easy (recipe book, assembly line) solution to a patient's health problem at hand, then it is the patients' responsibility to go elsewhere to find effective help on their own. Referrals to able and willing Specialists are not a Caregiver's problem or responsibility.

Important Note: The effect of this approach when virtually every Caregiver utilizes it (as they do), is that no Caregiver is willing to do the in-depth investigations necessary to help patients with complex chronic health challenges – so such patients just suffer what may very well be unnecessary illness and increasing misery until a premature death. This is either unacknowledged or ignored by individual Caregivers who feel personally excused and exonerated by simply professing that; “We (my specialty) doesn't do such in-depth investigations”, and presuming that such investigations are some other Caregiver or Specialist's job and problem. By leaving responsibility with the dismissed patient to find the Caregiver/Specialist they need, they never have to face the fact that no Caregiver in any Specialty is willing to take this responsibility on behalf of the patient. The patient becomes a hot potato, and never gets the in-depth investigations and consideration that their complex problems require for the possibility of effective treatment.

A Summarized Example of Ineffective Caregiver Response (to a complex chronic problem)

(Note: Ineffectiveness by design (due to the conventional system approach) is indicated by [InbyD])

- Please tell me one or a few symptoms.
(Unspoken: If you tell me more than a few symptoms I will gloss over and ignore them anyway, as I have only been programmed to recognize, acknowledge and respond to a limited number of symptom combinations as bona-fide disease [InbyD]. I will not even make a serious attempt to “connect the dots” with complex problems that involve more than a few symptoms [InbyD]).
- I will order some tests.
(Unspoken: The tests that are generally available in local labs for Caregivers to choose from are very limited. Those required for in-depth analysis of biochemistry or metabolism are often not available [InbyD]. Those tests that are available only recognize extreme results – indicative of acute, life threatening disease - as being out of normal range (or abnormal). Thus, all “sub-optimum” results which may be contributing to the symptom profile and indicative of the underlying health challenges will just be considered “normal” and will be ignored. [InbyD]).
- Your test results are normal, or, they have abnormalities but I don't know why.
(Unspoken: This is communicated in a “matter of fact” manner, with no sense of responsibility to investigate further until the cause of the symptoms (and/or abnormal lab test results) is found [InbyD]. This does not mean (as a naive, trusting patient is likely to assume) that the capacities of medical science to understand the underlying problem have been exhausted. It means that I as a Caregiver am not willing (and perhaps not able [InbyD]) to recognize any problems except for extreme deregulations of metabolism that can be identified by cursory testing [InbyD]. If your symptom profile and test results do not match one of a very limited number of symptom clusters that are recognized by a system approved label (or disease name, which has a pre-approved recipe book treatment), then I/we will not recognize it as illness at all. [InbyD]. Instead, we just dismiss the symptoms and patient as though the problem didn't exist, or as though nothing more can be done, with no further investigations, and no sense of guilt. Next patient please. [InbyD]
- I can offer you these meds.
(Unspoken: All of the meds offered will be designed only to suppress symptoms over the short term, so they will not address the underlying core problem (which has not yet been identified, and likely never will be with this conventional approach that is generally followed by all Caregivers, regardless of Specialty) [InbyD]. Thus, the underlying problem will most probably progress over time, so the meds will likely only suppress symptoms temporarily, and since the meds will likely have toxicity, they will also likely cause long term side effects that will make you even sicker. [InbyD]). However, when side effects do emerge, the system will be happy to write you more prescriptions to suppress those symptoms, so you have to buy (ever more) meds, indefinitely. [InbyD] (However, note the extreme effectiveness by design – of the long term sales and profit maximization of prescription drugs that results from this approach).

It is **very important** to note that in the (all too common) general scenario presented above, although every instance of ineffectiveness by design [InbyD] is a direct result of a perception, attitude, action (or inaction) of a Caregiver - in every case it is the system (in one or more ways) that encourages these responses, and discourages a more effective approach. If this were not the case, these ineffective approaches to diagnosis and treatment would not be so common or endemic to the system.

PART 3: EXAMPLES OF MAJOR SYSTEMIC BARRIERS TO EFFECTIVENESS

- Front line Caregivers are victimized by the system almost as much as patients. They are understaffed and overworked, and support (such as lab tests and testing facility) is underfunded and deficient. This discourages overwhelmed Caregivers from taking the time required to do thorough investigations or to learn new approaches. It discourages any approach other than pre-approved assembly line, recipe book medicine - the limitations of which ensure that complex chronic cases are not given the extra attention they require to be treated effectively.
- Caregivers are mostly compensated for quantity, rather than quality. Compensation is often based on quantity (of consults, or procedures) rather than measures of quality (for effectiveness or degree of recovery). When the system does not compensate for effectiveness, we cannot realistically expect it.
- Because of the points made above (under-staffing, a poorly designed basis of compensation, and underfunding of support) the jobs of most front line Caregivers can be described as a relentless treadmill, where an assembly line, recipe book approach to medicine must be adopted out of necessity to provide some semblance of health care to the overwhelming number of Patients per Caregiver. The outrageous Patient to Caregiver ratio is a totally unnecessary outcome of the current system design. It results in ineffective treatment for those patients who need more than a rushed time allotment to be treated effectively. The same relentless rush also undermines job satisfaction for Caregivers (to the degree of being abusive for many, and especially for those who truly want to provide more effective care - but can't because “the system” won't permit them the time or resources). To further discourage effective treatment, those Caregivers compensated on a fee per consult or service provided basis, are rewarded for pushing through the greatest number of patients in the least possible time. This is a dis-incentive to thoroughness, investigation or learning, as Caregivers are financially punished for “wasting time” with such initiatives.

Something is clearly very wrong here. There is no (justifiable) reason why the system has to contain so many dis-incentives to the provision of effective treatment. The system could alternatively be designed to compensate quality (effectiveness) at least as much as quantity (efficiency), and to encourage (through medical culture, compensation and support funding) more thorough investigations when needed, to arrive at conclusive diagnoses of underlying metabolic problems (to whatever degree is possible), and thereby provide the most effective treatment available for each patient, without delay.

Such an approach would restore treatment effectiveness as the highest priority of medicine (in practice as well as in theory). The increased treatment effectiveness would reduce the mistakes and sub-optimum treatment inherent to rushed Caregivers (saving countless lives and untold misery).

Contrary to system promoted propaganda, increased treatment effectiveness would also act to reduce total long term health care costs per patient, while enriching the job design and job satisfaction of Caregivers (without penalizing them financially). This would act to attract more students into medicine, and would enhance job retention by reducing frustration and burn-out, alleviating Caregiver shortages. Increased effectiveness would also reduce apathy as an almost necessary coping strategy for Caregivers. Finally, it is likely to greatly reduce the occurrence of the Health Care horror stories inherent to the current system that virtually every family has experienced, that have been increasing (in a direct correlation with the “improvements” to the system, made over the last few decades).

PART 4: WHAT HAS SHAPED THE MEDICAL SYSTEM TO BE INEFFECTIVE?

The following is evident to me, through my 25 years of interaction with the Health Care System as a frustrated patient (which has compelled me to figure out why the system has been so consistently ineffective for me, and others like me). The insights below were facilitated by my personal background of business experience, and teaching post-secondary classes in micro-economics, macro-economics, marketing, management theory, and human resource management - with a specialized interest in the shaping of organizational culture (employee values and perceptions) to maximize the achievement of organizational goals (the most primary of which, is usually profit).

- Big Pharma (and the entire Medical Industrial Complex) is primarily motivated by profit. Sales and profits result from illness rather than health, so there is no real incentive to cure chronic disease, or to help patients recover from a deregulated metabolism (that may underlie their disease). In fact, there is direct financial incentive to perpetuate such illness and not address it effectively. Thus, focus is placed on the research, marketing and sales of symptom (only) relieving drugs (that cure no-one), and the entire medical system has been hijacked and shaped (over many decades) to increasingly serve financial agendas (at the expense of effectiveness). Treatments that only suppress symptoms tend to be the only ones promoted to and by Caregivers, even when more (scientifically sound) effective approaches are available. Other major players within the Medical Industrial Complex have also exercised (and continue to exercise) whatever influence they can to shape the system to serve their own financial interests.
- Big Pharma (by far the most profitable industry in existence) and the Medical Industrial Complex under its umbrella - directly or indirectly contributes to the financing of medical education and training (pre and post grad), to selectively influence what is taught, to shape medical approach to serve their primary agenda (of sales and profit). Industry leaders are very conscious of the fact that “excessive” effectiveness (recovery and cures) would act to reduce their profits and growth. The Medical Industrial Complex also directly or indirectly funds and supports Medical Associations and have powerful, well financed lobbies to influence all levels of medicine (from Drug Reps who visit individual Clinicians, to powerful political lobbies of Medical Associations and Govt). This is not a wild conspiracy theory. It just recognizes how large corporations do business in any industry - which includes shaping systems, perceptions, culture, rules and approach in any way they can to enhance their profits.
- Out of fear of reprisal, Caregivers tend to be down on any approach that they are not already up on. The problem is, the current paradigm of treadmill paced, assembly line medicine means that they do not have the time to be up on any approach other than the recipe book approach (with periodic updates and reinforcement) that the system spoon feeds them. With regards to their fear of reprisal, it doesn't matter if there are alternative approaches that are equally or even more scientifically sound (that would provide much more effective treatment for some patients). It also doesn't matter how much unnecessary misery and death results from their refusal to venture from conventional, system approved, recipe book approaches. Caregivers are generally only familiar with the system approved/promoted approach, and as long as they follow this approach (even when it is clearly ineffective) - they do not have to fear reprisals (from patients, their survivors, or from the system). The current system protects and rewards Caregivers for their allegiance to (often less effective or ineffective) system approved approaches (that are often profit or cost focused), and thereby discourages and intimidates Caregivers from investigating and providing the most effective treatment available for each and every patient.

- There is an ongoing push from the top to “standardize” the medical approach of front line Caregivers (with a rationalization that it will improve quality of service). In fact, it will centralize control and further tie the hands of Caregivers by further limiting their discretion - with a stricter enforcement of standardized responses. This generally translates into a greater enforcement of even more narrowly prescribed recipe book, assembly line medicine, that will act to further reduce effectiveness (by reducing Caregiver discretion to respond appropriately to the needs of individual patients – which can differ greatly). Since effectiveness (cures and recovery) threatens industry profits and growth, the system has been insidiously shaped to ensure “ineffectiveness by design” (for complex chronic problems). There are many systemic barriers to effectiveness (some of which are presented above). The initiative to centralize control and further restrict Clinician discretion over how they treat patients, is just one more example of how system promoted ineffectiveness by design continues in its initiative to hijack medicine ever more, to increasingly serve a financial agenda. This hijacking has become so extensive and blatant in recent years, that it is becoming increasingly difficult for system guardians (and minions) to hide and rationalize it away with excuses and propaganda.

- Individual Caregivers may face repercussions from upper level managers (who are in effect, appointed guardians of the system) if they refuse to accept the system and its conventional approach. Caregivers who speak out against ineffective system approaches or practices, or who reject the limitations of conventional approach - risk punishment from medical authorities, and rejection by indoctrinated peers. Many Caregivers in this situation are intimidated and fear loss of status, employment and income, and thereby close their mind to the ineffectiveness inherent to the system. They may also turn their head to the limitations of the shallow, conventional recipe book approach to treatment. The illegitimate intimidation of lower level Caregivers and Health Care Workers causes the financial interests (of those who are responsible to provide care) to take precedence over the interests of effectiveness (for the patients who receive that care). This dynamic operates to undermine effectiveness at many levels within the system (from Industry CEO's and Politicians at the top, down to front line Caregivers at the bottom).

- However, some Caregivers are so indoctrinated by the system propaganda (which promotes convenient but shallow rationalizations for ineffectiveness), that they do not realize (and may even refuse to consider) that superior medical approaches to complex medical problems even exist, even when such approaches are supported by extensive science, solid research and documented clinical success. Enlightening the consciousness of such highly programmed and indoctrinated people is not easy. Rationality and facts are not sufficient. “It is difficult to impossible to make someone understand something, if they think it serves or benefits them not to understand it”. Due to intimidation, Caregivers may choose “not to see” the limitations of the system, or to acknowledge that superior, scientifically proven alternative approaches (that the system has discouraged their awareness and acceptance of) even exist.

- While Clinicians focus and deliberate whether or not the latest symptom relieving drug is superior to older symptom relieving drugs, medical science has completely re-framed the questions that need to be asked. Clinicians need to rise above the (system encouraged) distraction of meds that only offer to temporarily relieve symptoms (at best) - to utilize the complexity of modern bio-chemistry and metabolic science in an initiative to recover health, to whatever degree that is currently possible.

PART 5: WHAT DO I NEED FROM MY CAREGIVERS ?

- 1) I need my Caregivers to acknowledge the limitations to treatment effectiveness that are inherent to the system. I also need them to recognize the limitations of the prescribed conventional approach to treatment that they utilize, and that many of these (system and approach) limitations are unnecessary and unjustified, and only exist to serve agendas secondary to treatment effectiveness (such as financial agendas or job security).
- 2) I need my Caregivers to perceive their role in my health care in such a way that their perceptions will be instrumental to maximizing my chance (and the chances of other patients with complex chronic illness) of receiving effective treatment. These critical perceptions of their own role were specified previously in this document.
- 3) I need my Caregivers to reject the (system prescribed and supported) perceptions of their role that are instrumental to treatment failure or ineffectiveness. These invalid myths and dis-empowering perceptions were also specified previously in this document.
- 4) At the micro level - I need my Caregivers to abandon conventional approach when it is not effective and to consider and learn additional (scientifically based) approaches when they hold promise of greater treatment effectiveness for me (which would also likely help them to better treat other patients with similar or overlapping complex chronic health problems).
- 5) At the macro level - I need my Caregivers to stand with me (and invite their peers) in a call to denounce and change those aspects of the system that impose unnecessary limitations on the ability of Caregivers to provide effective treatment. If the system discourages Caregivers from doing thorough investigations and providing conclusive diagnosis and effective treatment for complex chronic illness, and, the system successfully discourages individual Caregivers from utilizing any other approach - then my only hope for effective treatment is to change the system. Caregivers who refuse to abandon their own conventional approach (even when it is not effective), and those who resist acknowledging the need for significant system change - are part of the problem, rather than part of the solution.
- 6) I need my Caregivers to provide (or refer and oversee) a thorough investigation to arrive at the most conclusive diagnosis possible - that explains the underlying cause(s) of my health challenges, tying together my (now) extensive symptom profile and many abnormal test results, with one (or a few) common root causes. I need them to be relentless in this initiative, and to accept nothing less than a complete (or near complete) explanation for my symptom profile and abnormal test results. I need them to enlist (and oversee) as many Specialists in this pursuit as is necessary to get the job done. If this requires the participation of rare specialties (such as Metabolic Geneticists) - then so be it.

Re My Primary Caregivers

Since none of the many Caregivers that I have ever seen has been willing to conduct (or orchestrate) such an investigation (as every one considers it to be some other Caregiver/Specialist's job), I have had little choice but to continue lobbying my primary Caregivers for the care that I need – trying to help by learning and doing my own investigations as best I could, and then providing them with lead after lead of potential underlying or contributing problems, hoping to spark interest and follow-up in the form of thorough investigations, or referrals for such.

In my opinion, my Primary Caregivers are the best that my city has to offer. They have been as open, cooperative and as giving of their time as “the system” will permit (and then some). The depth of analysis that I require should have been conducted by (at least some) of the many Specialists I have seen over the years. The fact that none have taken or accepted this initiative is testimony that the problem is systemic. I have no doubt that most of these Specialists were also well intentioned individuals (or at least had been when they entered the profession) – which further illustrates that there are major systemic problems that discourage them from doing the thorough investigations required to diagnose and treat complex chronic medical problems effectively.

However, after 25 years of progressive debilitation, unless something changes relatively soon, I will likely go to my grave - still waiting for a thorough analysis to be initiated and conducted.

PART 6: POST SCRIPT – ARE MY EXPECTATIONS OF CAREGIVERS REALISTIC?

In the following section, I will relate another story from my own experience, that should serve to illustrate that a more effective approach to medicine is possible, in Saskatchewan.

a) A Story of Success - Chapter 1

In the mid 70's I had a herniated disk in my back. I was referred to Dr. Kirkaldy-Willis, who was a Back Surgeon and Head of Orthopedic Surgery at the U of S. He insisted that every patient that came to him for surgery must see his (carefully selected) appointed Chiropractor - for at least 2 weeks of treatments before he would consent to perform a surgery. As a result, 50% of patients referred to him did not need surgery at all. Chiropractic was still rejected by most conventional medical professionals at the time. He didn't care. It saved 50% of his patients from needing surgery.

Every patient who went for their first consult with Dr KW, had a consult with a Neurologist in the same office immediately afterwards (who would assess nerve involvement and damage). Next, a Physiotherapist would come into the office to do an assessment of muscle involvement and damage. Right after that consult, a Chiropractor would come in (to assess bone involvement, alignment or damage). All of these Specialists were carefully selected members of Dr KW's team. The initial four consults all took place within a couple of hours. After these consults were completed, the four Specialists would all sit down to discuss their findings with each other – together coming up with a diagnosis and treatment suggestions. Dr KW would then come back to consult with the patient again, with the team's findings and recommendations. For the patient, this all took about a half day.

Dr KW could have confined his attention to his specialty of Surgery, and simply recommended that his patients make appointments and go and see all of the other (possibly pertinent) Specialists in their own offices. But this would have taken each patient weeks to months (if they would have bothered at all), and would have foregone the synergistic benefits of a multi-discipline team consult immediately after examination. Such an approach would have clearly resulted in much slower medical care, that would (in most cases) also be inferior to the team approach (where every member would grow to appreciate the other Specialists' contributions to a complete understanding of patient problems). In colloquial terms, four heads are better than one, and half a day is better than several weeks to several months (or even years).

Unfortunately, I was part of the 50% that was not helped by the chiropractic treatments, and needed an operation for a herniated disk. When in the Surgery Ward, the nurses informed me that by Dr KW's orders, (contrary to standard procedures on most Hospital Wards at the time), his patients received no enemas before surgery, and neither were his patients' surgery sites shaved before their operations. He felt that these “standard” procedures caused unjustifiable discomfort for patients. As well, during his daily morning rounds to see each patient on the Surgery Ward – if he ever found out that a patient had been experiencing significant pain, the nurses would be “severely raked over the coals” (as explained by one of his nurses). He simply would not stand for any patient experiencing unnecessary pain.

As well, most failed back surgery is caused by scar tissue that puts pressure on nerves, so Dr KW had another Surgical Specialist on his team, who did nothing except open and close the operation site, to ensure a minimum of scar tissue. He also employed an unconventional practice of leaving a small part of the incision open, with a small tube going into the incision that drained fluids that could have otherwise accumulated into scar tissue.

The tube remained in place for about 2 days or until drainage ceased. This took some creative adjustments to regular hospital bedding, as the patient had to lay on their back (comfortably) after the operation, but could not lay on the tube.

Dr KW had also (with the help of his team) designed a unique supportive but flexible and comfortable back brace for surgery patients to wear after surgery (which was manufactured locally and sold in a local store at cost). It was designed to take the strain off of their (cut and healing) back muscles and get them back on their feet faster, and with less pain. Designing and arranging the production and retail availability of an effective post surgery back support is not the job of a Surgeon or of any of the other Specialists on Dr KW's team, but it enhanced treatment effectiveness (which was Job #1 for these Caregivers), and so it was done. Conventional roles and expectations were simply not permitted to limit their pursuit of their primary mandate of treatment effectiveness. Period.

When I was first presented with the option of surgery, I was 21 years old and somewhat scared by the prospect. I conveyed my fear to Dr KW's long time receptionist, and asked her what percentage of patients died during back surgery? She replied that Dr KW had never had a surgery patient that did not walk out of the hospital under their own power after their operation. Dr KW was close to retirement age at the time. His success rate as a Back (and Orthopedic) Surgeon far exceeded those Surgeons who simply accepted and followed the system prescribed conventional approach. His focus and drive for effectiveness (regardless of convention) resulted in a success rate that gave him international recognition.

He performed my operation, and after a period of rehabilitation my back was pain free again. I regained enough strength to be able to move pianos, and it stayed strong for three decades.

A Story of Success - Chapter 2

There is a second part to this story. A few years after this very positive (Sask) medical experience, I married. A few years later my wife began experiencing sharp stomach pains that we suspected to be associated with a pregnancy. We went to a local Gynecologist here in Moose Jaw, who said that it may be an ectopic pregnancy (in a fallopian tube), but that "we would just wait and see what happens" (even though she was having frequent and severe pains). So I read everything I could find about ectopic pregnancies. Every source I could find said that a suspected ectopic pregnancy should be investigated without delay, because if/when the fetus grows enough to burst the fallopian tube, the woman could bleed to death internally before the bleeding could be stopped with emergency surgery.

Since the local Gynecologist had neglected to do the investigations called for in medical literature, I called Dr KW (who was then retired) at home, to ask him if there were any Gynecologists that he could recommend, since we had no time to "shop around" for another Doctor, and no time for any more of the complacency we had rec'd from the MJ Gynecologist. Knowing Dr KW's impressive, professional, teamwork approach to medicine, I wanted to tap into his personal network.

Dr KW told me to contact a particular Gynecologist in Saskatoon (Dr Gilliland, if I recall his name correctly). Dr KW gave me his private number and told me to tell Dr Gilliland that he had referred me. I called Dr Gilliland and conveyed the situation to him. He told me to bring my wife to a Saskatoon hospital immediately, and to ask for him as soon as we arrived. Upon our arrival, she was admitted for testing that confirmed an ectopic pregnancy, which Dr Gilliland removed in surgery later that evening. My call to Dr KW in the morning resulted in the necessary surgery being done that evening.

Notice that when I called Dr KW about the possible ectopic pregnancy of my wife, he did not second guess me, or put me off, or dismiss it as “not my specialty” or “not my problem”. He sent me straight to the medical professional who could, would and did provide the investigation and treatment required to help me, without delay. This may have saved my wife's life.

Note that if I had just accepted the apathetic approach of the Moose Jaw Gynecologist, my wife very possibly could have died. Please realize, that if she had died, he probably would have felt no personal responsibility whatsoever. When Caregivers utilize such an apathetic, dismissive response (that lacks immediate and thorough investigation), it will inevitably result in some patients dying or living in misery – unnecessarily. Such approaches could explain many medical tragedies.

After my wife's surgery, Dr KW also phoned me back a few days later to make sure that my wife's health problem had been handled effectively. Had it not, I suspect that he would have been on top of it immediately, as he was a Doctor, and a Professional – in spite of “the system”, and even when he wasn't working or being paid.

Note that the above experiences with Dr KW occurred in Saskatchewan - approx 30 years ago. With decades of scientific, medical and technological progress since then, is it realistic to expect at least the same level of service and professionalism now? If you point out that the system doesn't allow such good service anymore, I will agree – and reiterate that the presence of unnecessary systemic barriers and sub-optimum approach is the major point of this communication.

Dr KW was very good at what he did, and he did not hesitate to employ investigations and expertise outside of his own specialty, and even outside of convention – to ensure that patients under his care received effective treatment, without delay.

A Story of Success - Chapter 3

This story is still not over. There is a third part. I had a (slightly younger) relative who developed a herniated disk (like mine) about a year after my operation. I recommended Dr KW whole heartedly, but this relative lived closer to Regina, and chose to consult a Surgeon there instead (presuming a similar level of care). The Surgeon that he chose did not have him see a Chiropractor before consenting to Surgery (which from Dr KW's experience, reduced the need for surgery by 50%). The Surgeon just proceeded to give him a back operation for his herniated disk. This Surgeon also did not have a specialized “Open and Close” Surgical Assistant, to minimize scar tissue. My relative's back pain did not resolve after his operation. He suffered for years and kept going back for help. He endured two more operations (with ever increasing scar tissue) and still has significant back pain, which forced him into an early semi-retirement.

I have conveyed my relative's experience in contrast to mine, because it clearly shows that in the long run, it does not cost more to be thorough if it increases effectiveness, even if the up-front costs of a thorough investigation, conclusive diagnosis and effective treatment may be greater. I am sure that my relative's back problems (with countless visits to the Doctor, chiropractor and physiotherapists, and 3 operations) ended up costing the Health Care System far more than my back problems did, not to mention the cost to the Govt of his early retirement and disability payments. The much greater total financial costs of ineffectiveness do not even consider the added cost of personal suffering and loss of quality of life that my relative endured - that had a good chance of being unnecessary, had he been treated with a more thorough and effective approach in the first place.

b) Re The Need for Responsible Referrals – with Follow-up

No Medical Professional can have expertise in all areas, so the most we can expect (and the least we should expect) is that they have done their homework, and made the inquiries and contacts necessary, so if they cannot help a patient with a problem that is outside their expertise, that they will give that patient an immediate referral to a Caregiver that can (and will) help.

Referring Caregivers could also follow up on each patient's progress after referral, to ensure that they are referring to Specialists who are at the top in their field (or are at least, highly effective), and to ensure that the patient has received effective treatment without undue delay.

In those instances where a problem is complex and the first Specialist cannot conclusively identify the problem or provide the best treatment available, then this Specialist should (in turn) refer the patient to another Caregiver that can (and will) provide the investigations and treatment needed. If a referred Specialist (who cannot resolve the problem on their own) fails to make such a subsequent referral to access further needed expertise, the responsibility should fall back on the original referring Caregiver.

With this approach each patient will (eventually) get the most conclusive diagnosis medically possible – likely within a few weeks, and will (eventually and inevitably) either experience a recovery or will at least acquire the best treatment available for their problem.

New Doctors may consider such an approach to be somewhat radical, and perhaps even impractical. But older Doctors will testify that this approach better describes the way that referrals used to be handled a few decades ago, when Medical Professionals (without oppressive industry influence) designed and operated the medical system – with treatment effectiveness as the (rightful) primary goal.

Is this too much to ask today? I will not ask if it is possible within Saskatchewan with current technology. From what I have related above from 30 years ago, that should be evident.

Notice that in the above experiences that model treatment effectiveness, there was no second guessing (except in the treatment failure by the MJ Gynecologist whose complacency needlessly endangered my wife's life). Except for this same morally negligent Gynecologist, neither was there any dismissal or trivialization of a patient or a patient's problems (wishing them all the best) because a particular Medical Professional did not happen to have the tools in their tool box to treat them effectively (within a few minutes).

The examples above should illustrate that the limitations of any one Caregiver (even within the current system, and regardless of Specialty) does not have to tie their hands and make them helpless (or apathetic), if they don't want it to.

PART 7: COULD DR. KW'S DIAGNOSIS AND TREATMENT MODEL BE (RE) EMPLOYED TODAY?

If we applied Dr KW's model in the provision of Health Care Services today, what might it look like?

a) Regarding All Health Problems

If a new patient came to a Health Centre, could they be screened (based on symptoms and past test results) and sent to one (or more) Specialists (ideally, within the same complex), whom they would see within a day or two?

Could one Caregiver be appointed as primary advocate - to oversee the process and ensure thoroughness, expediency and maximum effectiveness?

Could each Specialist order tests (to be done within a day or two) that would be placed online within a few hours of completion – so they (and all subsequent Caregivers) would have access thereafter?

Could each Specialist (after the initial consult and evaluation of the results of any tests they ordered), then recommend the additional consults of other Specialists (which would also similarly take place within a day or two)?

Once all Specialists considered relevant to the the patient's problems have consulted the patient and conducted any tests necessary to unravel the underlying cause(s) of their symptoms, could all of the Specialists involved then consult with each other to determine underlying cause (to whatever degree is possible), and to determine optimum treatment (or, further referrals and investigation)?

Note that this approach would provide a patient with a thorough investigation and superior diagnosis and treatment decisions - through the combined efforts of as many Specialists as would be necessary, at a rate of approx three to four Specialists consults (with tests) per week. (Note: This approach very closely describes the working model and efficiency of the Rochester Mayo Clinic over 20 years ago, so it should certainly be plausible today).

With the current conventional system (that we unconsciously accept as optimum or as “given”), how long does it take a patient to see four consecutive Specialists (none of whom conducts a thorough analysis, with no-one responsible to reconcile their respective findings, and no team effort to provide a reconciled conclusive diagnosis)? Months to years? (if ever). Note that such delays and ineffectiveness are simply due to poor system design and are entirely unnecessary. The current system does not even serve cost effectiveness when long term total costs are considered.

b) With Specific Regard to Mental Health Problems

Note that the above described approach could also incorporate a seamless integration between the treatment of physical and mental health problems, when patients' health challenges include (or may include) mental health symptoms. Neurology and biochemistry (and the increasing contributions of genetics) would provide the links that would reconcile the quests of physical and mental health Specialists to work together to find the underlying metabolic/physiological causes of any health problem (whether it manifests in physical and/or mental symptoms). This would act to reduce the unnecessary stigma (and the barriers that stigma erects) to accessing effective treatment for those patients whose health problems may include mental health manifestations.

Automatic thorough investigations are even more important for mental health patients, who more often lack the capacity to realize when the system fails to conduct a thorough analysis of their biochemistry - which could reveal addressable physiological causes of their mental health problems. These patients also tend to have a decreased capacity to advocate for themselves when the system fails them, which further justifies that thorough physiological investigations should be conducted automatically, without a patient having to ask (or fight) for them.

Removing the overly distinct delineation of physical from mental symptoms (which may often result from the same underlying problem) would also increase an open acknowledgment that mental health manifestations are common in most forms of chronic disease.

A greater acceptance that mental and physical symptoms are often both manifestations of a common underlying physiological disorder (that needs to be thoroughly investigated, identified and addressed, no matter what symptoms it manifests) would also serve to educate Clinicians away from the practice of dismissing patients with complex chronic problems (and excusing themselves from responsibility) with a presumptive diagnosis of mental health problems “instead of real medical problems”.

PART 8: REGARDING THE ROLE OF GOVERNMENT IN HEALTH CARE

When Health Care is ineffective (largely by design, as shaped by the Medical Industrial Complex to maximize revenues), it becomes a potentially bottomless pit for health care expenditures. Ineffective health care never saves money - it only wastes it. No matter how much is spent on ineffective health care, it will never be enough, as patients will still seek more (effective) health care. This “bottomless pit” can be described in another way; No matter how high the revenues of the Medical Industrial Complex, it will never be enough.

This situation begs for Government to (at the very least) step in and regulate those profit-focused industrial practices that compromise treatment effectiveness and act against public interest – with the goal being a system that is designed to maximize effectiveness (and thereby reduce total costs). Largely due to powerful political lobbying by Big Pharma and the Medical Industrial Complex (and other political considerations beyond the scope of this paper), no political party has (in many decades) had the political will to take on this initiative.

The Political power of the Medical Industrial Complex has now grown to the point that it is unlikely that any future government will risk attempting to end the ruse to make the system socially responsible (with the primary focus truly on treatment effectiveness, where it should be). No government action to address this problem is likely without rejection of the current system by the medical community and the public. Government may still be goaded into acting with a sufficient bottom-up call for system reform, designed and controlled by medical professionals - that is (truly) free from financial shaping and insidious corruption.

To date, government has stood by and watched as medicine has been increasingly hijacked to serve an industrial/business agenda, largely limiting their involvement to attempts to control escalating medical costs, with a primary approach of simply placing caps on total funding.

Tommy Douglas (The Father of Universal Health Care – recently voted the Greatest Canadian, by Canadians), said that health care reform required two steps; 1) Public funding (which he/we achieved). 2) A re-focus away from addressing illness and towards the recovery and maintenance of health. This second step has yet to be pursued, which underlies many of the current problems presented herein.

Health care that is publicly funded, also needs to be publicly designed and administered (to serve the best interests of the public), by publicly employed Medical Professionals, who are insulated from the financial influence of the Medical Industrial Complex. We have seen the legacy of Govt limiting its role to only providing funding, which has permitted the Medical Industrial Complex to shape the system to serve its financial agenda (often at the expense of effectiveness).

When Govt simply limits total expenditures, it only makes Health Care even less effective, by understaffing and underfunding all support services – including those that Caregivers need to provide effective Health Care. This has become such a problem that we now even have an increasing shortage of Caregivers (with even more tragic consequences on the horizon). Incessant short sighted (Govt sponsored) initiatives to ever increase efficiency (by reducing or controlling costs) have often been at the expense of effectiveness (and have placed unrealistic expectations on staff in the process). Such initiatives have largely shaped the rushed assembly line approach inherent to the current system (which is mistake prone and highly unlikely to provide consistent optimum treatment).

When Government under finances Health Care (and delegates difficult specific funding cut decisions to underfunded Health Regions), it virtually guarantees ineffectiveness somewhere in the system.

The Medical Industrial Complex has no problem with the frustration and anger caused by this ineffectiveness, as these interests would be very pleased with a public that is alienated against publicly administered health care. Industry would very much like to see a public frustrated sufficiently to accept privatized health care (as is present in the U.S.) - under an erroneous (but propagated) assumption that privatization would end hidden financial agendas and ineffectiveness by design. Indeed, there are powerful Industry funded lobbies acting to promote privatized Health Care in Canada, as they envision a privatized system to have even fewer limitations on costs/profit margins.

Note that the focus of Government (largely to minimize costs) is very similar to the focus of Industry (to maximize revenues), in that both focus on finances. Both approaches result in medical systems and approaches designed first and foremost to serve financial agendas (as opposed to treatment effectiveness). Thus, the outcome (of record breaking industry profits along with all too many instances of ineffective care) should be no surprise.

One alternative approach that Government might consider, is to start with “minimum treatment standards”, as opposed to starting with funding caps. If minimum standards were established for how long (maximum) that any Saskatchewan patient should have to wait (including travel time) to see a GP or Specialist, and how long (maximum) they should have to wait (including travel time) for each type of test and treatment – it would make it clear exactly how many Caregivers (and Specialists) are needed, what testing and treatment facilities are needed, and exactly where they are needed within the province – to guarantee these minimums to every Sask resident.

Once the minimum standards are determined, the “where and how many” of each health care service required would be relatively easy to determine. The cost would be as necessary to provide the minimum acceptable standards of care. In this way, the availability of (minimally acceptable) effective care would be the first focus and would be directly controlled, with funding as necessary to provide it.

This would be the reverse of the current approach, where funding caps are determined first (to serve political agendas) – which often results in underfunding that contributes to the subsequent horrific stories of health care that is so poor or flawed that such accounts often challenge believability in a developed country. Needless to say, such ineffective health care should be as unacceptable to Gov't, as it is to its direct victims (which include both recipients, and front line providers).

A further step to enhance treatment effectiveness would be to ensure that minimum standards of care would relate as much to quality of care, as they would to the mere accessibility of Caregivers and facilities.

PART 9: SUMMARY

This presentation consisted of :

- a Prelude, providing the author's personal experience to illustrate wide spread system failure.
- A Core Presentation - which explains how and why system failure is so prevalent.
- A Post Script – which provides a model of treatment success, also based on personal experience and observation.
- A model of how Health Care might look today, if an effective approach were (re) employed.
- A commentary on the role of Government in shaping our Health Care System.

I think it is important to understand that the difference between effectiveness and ineffectiveness ultimately lies in the perceptions and approach of Caregivers - but that their perceptions and approach are (unfortunately) highly shaped by a system wrought by ineffectiveness (by design). This has resulted from a system that (over several decades) has been ever more re-designed to serve an industrial/financial agenda, often at the expense of treatment effectiveness.

I hope that you may have found this composition at the very least - interesting. My greatest hope is that it may help raise consciousness to induce positive change, for the sake of all current and future patients (and especially those with complex chronic health challenges) - who will continue to face the same unnecessary treatment barriers that I have faced, and am still facing.

But I also hope for change for the sake of the (treadmill bound) Caregivers who work in the current (hijacked) medical system, who are also often intimidated and victimized as pawns of the system. The honorable title and profession of “Doctor” or “Caregiver” grows ever more tarnished by tragic horror stories of (unnecessary) treatment failures, which tend to be blamed (explicitly or implicitly) on the Caregivers involved. It is time that responsibility for the preponderance of such failures is rightfully placed upon the prevailing (hijacked) medical system - which victimizes both front line Caregivers and Health Care recipients by virtually guaranteeing a significant degree of treatment ineffectiveness.

The first and major step in addressing such an insidious problem is to acknowledge it.