The HealthCare Papers

Research In Search of an American Health Care System

Edited By
Stephen F Hightower MD FACP
T Michael White MD FACP

NEW!!
#15 None Are Protected Unless All Are Protected
Dana S Kellis MD PhD and Stephen F Hightower MD
Page 59

Table of Contents

I. Prologue — The HealthCare Papers 4
II. About the Editors
III. Submissions — Encouragement and Format
IV. Relevant (Proudly Purloined) Links
V. Opinion Editorials and Comments

#1 Our “Insured” Near and Dear Are Uninsured
Stephen F Hightower MD and T Michael White MD

#2 Our Health Care System Is Broken
T Michael White MD

#3 Health Insurance — The View from the Trenches
Kalim Ahmed MD

#4 Medicare — Not Free — Is a Worthy Investment (Worth Sharing)
Stephen F Hightower MD and T Michael White MD

#5 Logical, Functional, Affordable — COVID-19 Compatible — Health Care
Stephen F Hightower MD and T Michael White MD

#6 Single Payer Health Care — A Blessing
Jay Stearns MD and Stephen F Hightower MD

#7 Bulletin — You Are Now the Doctor
Stephen Hightower MD and T Michael White MD

#8 Understandable and Explainable End-of-Life Desires and Wishes
Stephen Hightower MD and T Michael White MD

#9 When I’m 84 Part 1 — The Challenge of Progressive Disease in the Elderly
Stephen Hightower MD and T Michael White MD

#10 When I’m 84 Part 2 — The Cost of Health Care for the Elderly
Stephen Hightower MD and T Michael White MD

#11 Two Health Care System Quick Fixes — The Consumer and Medical Liability
Mr. Charley David Price and T Michael White MD

#12 My Hope for the Future of Health Care
Ms. Maureen Theriault MA BA and Stephen F Hightower MD

#13 Triskaidekaphobia — Moving On

#14 When I’m 84 Part 3 — The Debate About the Rationing of Health Care
Stephen F Hightower MD and T Michael White MD

#15 New!! None Are Protected Unless All Are Protected
Dana S Kellis MD PhD and Stephen F Hightower MD

VI. Long Reads: Essays and Fictions

#1EF Medicide — A Failure to Make Whitefish Bay
W Ryder Black

#2EF Coronavirus — Our Health Care System Exposed
David Emory Lippman MD
#3EF 2-Club Pandemic Golf — *Avoiding the Rule of Unintended Consequences*

*W Ryder Black*

#4EF Pandemic Golf

*Anonymous*

VII. Epilogue *(a work in progress)*

*To be continued...*
I. **Prologue — The HealthCare Papers**

The question must be asked — what is this *The HealthCare Papers — Research In Search of an American Health Care System*? There is an answer (a *raison d’être*) to this fair query.

Health care is a critical segment of our country’s infrastructure. Like airlines, railroads, highways, bridges, waterworks and power grids, health care is glue that enables society to function. But, to date, health care’s role in infrastructure is neither recognized nor systematically addressed.

The Bing dictionary defines a system as “a set of things working together as parts of a mechanism or an interconnecting network.” Familiar to many, Southwest Airlines, serves as an example of a system. Our nation’s health care does not conform to the definition. While miraculous care is provided daily, the circumstances are anecdotal not systematic.

Despite infinite potential, devastating physical and financial consequences of the failure to provide predictable access to basic affordable health care occur daily. Worse yet, leadership paralysis afflicts movement towards the design, implementation, maintenance and continuous improvement of solutions.

Drama aside, telling it plain, America’s health care is in crisis. Importantly, although this observation is amplified by the COVID-19 pandemic, it predates the pandemic and crisis will not be alleviated if/when the pandemic is resolved.

As physicians, we (Editors Hightower and White) recognize continued silence on our part equates to enabling complicity. Having solemnly sworn to careers advancing safe, timely effective, efficient, equitable (just), compassionate patient-centered care, we cannot abide silence. Privileged by experience in the trenches, we are obligated, with humility, to share our clinical and leadership perspectives and insist upon a health care system that cares for everyone.

The question — how may we best communicate concerns, communicate solutions and impact change? After a pilot involving dozens of thoughtful minds — administrators, clinicians and patients — we have come to understand:

1. We must take action;
2. Our tone must be professionally compassionate and kind;
3. Our strategy is to edit and publish this book, *The HealthCare Papers — Research In Search of an American Health Care System*, bit by bit on the web in real-time;
4. Our vehicle will be the webpage [www.thehealthcarepapers](http://www.thehealthcarepapers);
5. Delivery will be through an email list (please ask to be included; please forward to interested parties);
6. Submissions (opinion editorials, essays or fictions) will come from interested parties (please submit);
7. Thoughtful responses to a specific submission will be annexed to that submission (please respond); and
8. As an unimportant stretch goal, this book, completed, may one day be formally published so that it may be circulated in support of safe, timely, efficient, effective, equitable (just), compassionate patient-centered care. If worthy, please recommend this important, meaningful effort for consideration by editors and publishers in your sphere of interest.

Our raison d’etre clear — we are obligated, with humility, to share our clinical and leadership perspectives and insist upon a health care system — we embark. Recognizing a solemn duty, we pledge balanced accuracy. As we proceed, we are confident that wise perspectives, willingly shared will prove vital. Humbly, we understand impact will be measured by salutary change.

Your insights are our GPS. They will guide, facilitate and validate our journey towards safe, timely effective, efficient, equitable (just), compassionate patient-centered care. We look forward to your perceptions (your reality) of right, wrong and/or omitted. We need and will be most pleased to hear from you.

Along the way, we hope to strike a chord. If/when we do, please explain to us how and why; and, please forward your thoughts to those you deem need to know. It will be the power of your opinion that will provide the gravitas to the discussion beyond that which we would ever hope to achieve.

Respectfully submitted,

Stephen F Hightower MD FACP
thcpsfhmd@gmail.com

T Michael White MD FACP
thcptmwmd@gmail.com
II. About the Editors

In a 34 year medical career, Stephen F Hightower MD FACP has been appointed as an assistant clinical professor of internal medicine and geriatrics. He has addressed clinical medicine with the Public Health Service, in group practice, and with a health maintenance organization. Medical students and residents in Pennsylvania, Texas and New Mexico have been influenced by his teachings. He has served in medical staff leadership roles. Currently his professional work is dedicated to advocating for universal access to health care. Dr. Hightower can be contacted at thcpsfhmd@gmail.com. He will be pleased to hear from you.

T Michael White MD FACP, a general internist, has served as a clinical professor of medicine. His career has addressed clinical medicine, the training of medical students and medical residents, medical staff leadership, hospital administration and regional and national medical affairs. Now an author, his writings and professional work currently concentrate on advancing health care value (value = quality plus safety divided by cost). Dr. White can be contacted at thcptmwmd@gmail.com. He will be pleased to hear from you.
III. Submissions — Encouragement and Format

Submissions directed at the advancement of an American health care system are encouraged. Without interfering with creativity, yet in the interest of readability, the editors advocate the following format:

1. Consider that you are submitting an opinion editorial (an Op-Ed);
2. Provide a title;
3. Be concise (<650 words);
4. Stay on message (i.e., two important messages may best equal two submissions);
5. Submit as a Word document (not as a PDF) so editors may efficiently cut and paste;
6. Include a cover letter that states:
   - you (the author) consent to publication in our webpage book; and
   - briefly describes who you are (i.e., declare your perspective);
7. Submit to Dr. Hightower thcpsfhmd@gmail.com or Dr. White at thcptmwmd@gmail.com for consideration;
8. Please understand that your submission may be published with minor edits;
9. Please understand that received and then edited thoughtful, professional, compassionate and kind comments (for or against) may be annexed to your submission; and
10. Please understand that all submissions may not be accepted for publication.

or

1. Submit a relevant essay or work of fiction;
2. Submit as a Word document (not as a PDF) so editors may efficiently cut and paste;
3. Include a cover letter that states:
   a. you (the author) consent to publication in our webpage book; and
   b. briefly describes who you are (i.e., declare your perspective);
4. Submit to Dr. Hightower thcpsfhmd@gmail.com or Dr. White at thcptmwmd@gmail.com for consideration;
5. Please understand that your submission may be published with minor edits;
6. Please understand that received and then edited thoughtful, professional, compassionate and kind comments (for or against) may be annexed to your submission; and
7. Please understand that all submissions may not be accepted for publication.
IV. Relevant (Proudly Purloined) Links

From time to time, important, relevant, articulate opinions may become manifest. For the purposes of sharing, remembering and reference, they are warehoused here:

- A Better Health Care System for All (ACP)
- My $145,000 Surprise Medical Bill (NYT)
- America’s Healthcare Gets Worse (NYT)
- Improving the Prognosis for America’s Health Care (Lancet)
- Type 2 Diabetes Statistics and Facts (Medical News Today)
- Health Insurance with Less Coverage (Bloomberg)
- Good RX --- Lowest Drug Prices
- Coronavirus and Health Care for Some (NYT)
- Ethics and the at High Risk Doctor (NYT)
- Coronavirus Testing --- Hidden Costs (NYT)
- The World's Cheapest Hospital (Bloomberg)
- How to Edit Your Own Writing (NYT)
- Bernie Sanders: The Foundations of Society are Failing Us (NYT)
- American College Of Physicians New Vision for U. S. Health Care System
- Trump Vows Termination of Obamacare Despite Pandemic (WP)
- Alan Alda Commencement Address 1980 (Connecticut College)
- America's Cities Could House Everyone if They Chose To (NYT)
V. Opinion Editorials and Comments
Good Readers, please allow a bit of context for this first submission. Just prior to the end of year 2019, our strategy for the advancement of a health care system was to submit cogent op-eds to leading national and regional newspapers. Our first effort was submitted to the New York Times:

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Our “Insured” Near And Dear Are Uninsured

As you consider your New Year’s resolutions, please join me in understanding that we are in the midst of an unpublicized and unaddressed health care crisis — our “insured” near and dear are uninsured. Although beyond-affordable health care premiums are being collected, health, wealth (hearth, home, employment, education) and peace of mind are not protected (insured). Then, resolve accordingly.

The near and dear I refer to are not our elderly infirmed. Medicare safeguards them (at least until 2026). Each day it is our educated, gainfully employed, industrious young who face illness/accident-generated financial ruin. Under the pretense of protection by employer provided health insurance, they are essentially uninsured. “Insured” millions are exposed to and, when cognizant, live in fear of the financial consequences of illness or accident.

Only those protected by privileged health care coverage backed by immense wealth are immune. Consider the predicament of an imaginary favorite niece — a recent law school graduate who we are all proud to say we know well. Aided by blue-collar parent planning and sacrifice, she left law school debt free. Signing on with a major firm in a major metropolitan area, she embarked upon her hard-won “dream career.” Hours long and salary short, she shared expenses with a colleague. A second job tending bar assisted with cash flow.

She and her housemate might have been twins separated at birth. Apart, they shared identical family, high school, athletic, college and grad school experiences. A major difference — her roommate entered her profession burdened with massive educational debt.

Already a conservative type, at the insistence of her belt-and-suspenders type parents, our fine niece opted for employer-sponsored health insurance. She chose the least expensive (least coverage) bronze plan. After $7K in annual premiums, she faced $6K in annual deductibles. Essentially, she signed on to pay $13K before a first dollar of insurance would come into play. Her annual (note: it reloads annually) out of pocket maximum (after premium payments) would be capped at $7K.

To allay parental anxieties, she stated she was contributing to employer-matched health savings and retirement plans. Living paycheck to paycheck, with zero disposable income, she was not.
Despite a second job and best intentions, repayment of education loans precluded her roommate from participating in her employer-sponsored health plan. Fearful of the consequences but too embarrassed to share her circumstance with anyone, she prayerfully soldiered on.

As merciful fate would have it, it was our insured lass who was stricken. After a simple viral infection, she developed profound weakness. Brilliant, compassionate caregivers’ diagnosis, treatment and prolonged rehabilitation proved miraculous — and fantastically expensive. Too weak to work, her parents came to the rescue. Placing secure retirements in jeopardy, they took her in and assumed her living expenses, insurance premiums and deductibles.

Partially recovered, she worked part-time. Although she could not afford health insurance premiums and deductibles, her income precluded public assistance. Nevertheless, all things considered, hers is the happy story. Had her roommate been stricken — parental backstop unavailable — she would have experienced illness-generated financial ruin. Dunned by the health care system until homeless, when asked — “How could this happen? How did so much potential turn to ruin?” — given to kindness, she might reply, “bad luck.” Pressed for accuracy, she would be forced to state, “a clueless, uncaring, insentient nation.”

Although our young lady’s illness is rare, her illness/accident-engendered circumstance is increasingly the case. This cannot remain the status quo. Leadership must stop saying “millions are happy with their health care insurance.” That truth became myth years ago. Leadership, for the sake of our country and their legacies, must now heroically step up, design and implement a health care insurance system that actually protects (insures) health, wealth (hearth, home, employment and education) and peace of mind for all Americans.

Please consider your New Year’s resolutions through this lens. Understanding that the potential consequences of uninsured “insured” illness/accident may become real for your near and dear, resolve accordingly.

Respectfully submitted,

Stephen F Hightower
Internal Medicine/Geriatrics
Rio Rancho, New Mexico

T Michael White MD
Internal Medicine/Health Care Value, Quality and Safety
Belleair, Florida

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All was well and good until, without feedback, our op-ed was not published. So we went to plan B. A mailing list of thoughtful administrators, clinicians, patients and friends received the following email:

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Sunday, January 5, 2020
Partners in Health Care,

Thank you for all you do daily so well for so many.

After professional review, improvement and encouragement, we submitted Our “Insured” Near And Dear Are Uninsured (please see your attached copy) to the New York Times for publication as an op-ed. Without explanation, it was publication unworthy. We realistically conclude:

1. An unworthy topic (doubt);
2. Amateurish prose (probably); and/or
3. Authors’ (lack of) gravitas (certainly).

Unbowed, with a message needing to be heard, we send Our “Insured” Near and Dear Are Uninsured to you.

Please give it a quick turn. If worthy, please forward, with the power of your gravitas, to those who may consider and influence.

Respectfully submitted,
Stephen F Hightower MD FACP
T Michael White MD FACP

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Many responses were forthcoming. They encouraged pressing forward for compassionate, accessible, affordable health care.

Since op-eds at the mercy of editors’ agendas and space considerations proved unworkable, our strategy changed. This webpage book, The HealthCare Papers — Research In Search of an American Health Care System, became our device.

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Responses to Submission #1 (January 2020)

Doctors, well written. Unfortunately, the myth that everyone has access to “affordable health insurance” is just that, a Myth!

Mr. Paul Sweeney/Health Care Insurance Executive/Maryland

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Doctors, well said! So true (for everything, although I take issue with ONE point): we don’t actually have a “health care” crisis. Health care is better today than in any moment in human history! What we have is a “Health Insurance Financial” crisis, and I, for one, resent the “Powers That Be” including healthcare providers in their scheme to rape the American people of their fortune, in order to reap enormous profits at our expense, all the while trying to include us in the blame. It’s going to require physicians like us educating the masses in order to steer the conversation in a useful direction. I plan on forwarding your letter to everyone I know.
Dr. Edward Aulisi/Chair, Neurosurgery/Washington, D.C.

******

Doctors, not an unworthy topic. Good prose. The problem lies in the fact that a large percentage of Americans are poorly educated and/or brainwashed. That explains why the American public consistently vote for politicians that represent the interests of large corporations rather than those of the public or heaven forbid, future generations.

Chief Red Cloud of the decimated Lakota Nation summed it up: “If you want what the white man has, you must do the following: first forget all the wisdom of your ancestors. Then fill your store house with more than you can use in a lifetime. After you have done that, go to your neighbor and steal everything that he has.”

Red Cloud described perfectly the mentality of those who are in power and why they continue to enrich themselves at the expense of present and future generations.

Many of us that have had the privilege of an education, as well as some who have not, who are endowed with an uncommon amount of common sense are aware of the problem that exists currently. None of us have an easy solution, hence the frightening expression “it is what it is”.

Unlike us, mother nature is already working on it. Just as our bodies develop a fever to rid ourselves of an infection....

Dr. Jay Stearns/Internal Medicine and Hospitalist Medicine/Indian Health Service (locum tenens)/New Zealand
Our Health Care System Is Broken

T Michael White MD

February 11, 2020

Editors The HealthCare Papers,

Telling it plain — the United States’ health care system is broken. More accurately, our proud, wonderful country does not have a system to protect our citizens as they endeavor to address illness and preserve health.

Circumstances are beyond critical. The healths, hearths and homes, employments, educations, dignities and peace of minds of the majority of our young citizens are now unprotected from accident or illness. Essentially, this is true for all (except perhaps for a tiny minority protected by immense wealth). Ask not when or for whom the bell tolls. It tolls for your and my near and dear.

Should you, through experience perhaps, be inclined to trust my observations, please verify. Call a well-educated, gainfully employed Gen X or Millennial (Gen Y) in your life and ask a series of questions:

• Does your employer offer a health plan? If yes...
• What is the monthly/annual premium? Can you afford the premium? If yes...
• What is the annual deductible? If accident or illness arise, can you afford the deductible? If yes, how? If no...
• Will inability to address deductible impact health, hearth and home, employment, education, dignity and/or peace of mind?

Prepared to be alarmed and then please become outraged.

Stephen F Hightower MD, an internist and geriatrician in Rio Rancho, New Mexico went through this process and reports:

“As I considered lending perspective, I reviewed the financial options for and implications of health care insurance offered in my own sphere of influence. For a midcareer professional working within a small firm (P = premium; D = deductible; OOPM = out-of-pocket maximum after premiums paid):

• Individual: P $7500; D $2000; OOPM $7400.
• Couple: P $15000; D $4000; OOPM $14800.
• Family: P $21500; D $6000; OOPM $22000.

I am first appalled and then frightened. Premiums (before accident/illness intervene) are unfathomable. The calculus of addressing deductibles is insurmountable. Bumping through one bad illness year, may be plausible; however, anything beyond that would have devastating career, family and life consequences.”

At this time, if an individual has the right diagnosis, finds himself before the right physician and can afford the freight, care, bordering at times on the miraculous, will be superb.
That is just too many ifs to be recognized as a health care system. Immediate design, implementation and maintenance of a health care insurance system that fosters and protects healths, hearths and homes, employments, educations and peace of minds is required.

Respectfully submitted,
T Michael White MD FACP
Health Care Value, Quality and Safety/Internal Medicine
Belleair, Florida

390 words

Responses to Submission #2 (February 2020)
Dr. Mike, the status quo is bad, but it could be much worse. Coverage for pre-existing conditions is currently required under the ACA, the future of which is uncertain. This Op-Ed could sustain another paragraph that presupposes that one or more of the challenges to the ACA before the courts will result in the law being declared unconstitutional (for unrelated reasons). You could add an entire hypothetical analysis of how that might further increase costs or, perhaps, simply pose the question rhetorically.

Attorney Jessica White/Kentucky
*****
Dr. Mike, perhaps if government funded med school for qualified candidates and they were paid by the government it would be a start. If we had single payer insurance eliminating for profit insurance companies I believe health care would be affordable. It will not happen but it’s a good idea.

Mr. Bill Gormly/CEO and Farmer/Vermont
*****
Dr. Mike, I commend you and yes this can be devastating to most individuals and families. I (on the outside of this) don’t really know what the Medical Community and Insurance Community can do. I can only hope that for the future (immediate future also) we get to a better system (and to get it “fixed”).

Mr. Bart Crivella/Commercial Real Estate/Washington DC
*****
Dr. Mike, thanks for including me on your list. Whew, it is scary for Gen X & Y. Not to mention the rest of us. You put forward a good case for health care reform. As a Medicare recipient, I have a long view of how health coverage helped us. I cannot imagine the decisions young people have to face without the benefits we had.

Mrs. Maureen Theriault/Editor and Public Relations Professional/Maryland
*****
Dr. Mike, there is no question there is a big problem with our health care system. The question is who has the answer? Is it the legislators, the hospitals, the doctors, the insurance industry or the drug companies? My guess it is a combination of all the above. If we had a legislature that was serious about this problem, I think they could get a panel of experts from all these areas and come up with some kind of solution. The legislators cannot solve this problem alone because they do not have the necessary medical or financial expertise to come up with a valid solution. The problem will eventually have to be addressed. Our medical care can not only be for the rich We have to find a way to include both rich and poor.

NCAA Coach George Reid/Purdue and Georgia/Maryland
*****
Dr. Mike, I fully agree. For starters why can’t the American people enjoy the same health insurance that our Congressmen(women) give to themselves. I’m sure this will stimulate a more honest debate in our hallowed legislative halls and make the debate truly inclusive for all Americans.

Dr. Mike Atardi/OB/GYN/New Jersey
******

Dr. Mike, I and others enjoyed reading your collaborative work with Dr. Hightower. There is a need for a website that can be a conduit for voices of pain and suffering, which provides insurance companies with data. Only then there may be room for change. Businesses only care if competition does better, hence the national health plan. Convincing Republican politicians may be impossible. They are happy with an elite health plan through the government — unavailable to others. What hypocrisy! While you keep working on change, we will keep the ball rolling with friends.

Dr. Raj Sandhu/Psychiatry/Pennsylvania
#3 Health Insurance — The View from the Trenches  

Kalim Ahmed MD

February 28, 2020

Editors The HealthCare Papers,

The HealthCare Papers concept has stimulated me to share my thoughts about the current status of medical insurance and its pitfalls.

Physicians see on-the-ground realities. Since we deal with patients from different socio-economic circumstances, we know what health insurance can and cannot provide; and we understand its potential for keeping the general population holistically safe and healthy. Sadly, the current private health insurance system has failed to meet its underlying obligations and objectives.

As we know, the modern insurance industry has evolved over time from the fire insurance for houses in 17th century to today’s much more sophisticated and elaborate policies. Now, each and every aspect of our life, business and commerce is entangled with insurance and without its existence our modern day life is unimaginable.

Insurance provides a safety network by promising to mitigate risk for individuals or organizations. In turn, this helps with the development and growth of the society. It is based on the concept that a large number of people/organizations will pay a fee on a regular basis and the money pool will be used for those few who will suffer predetermined loses or tragedies. The individual financial burden is thus minimized. With the security provided by insurance protection, rebuilt lives or businesses return as functional members of the society.

The current medical insurance system has completely failed to fulfill stated objectives. Growing monthly premiums, out of pocket expenses, deductibles, drug plan premiums and cost of uncovered medications leave “insured” individuals unprotected.

Although I am not qualified (it is above my paygrade) to dissect the complexity of health insurance’s predicament, let me share my observations: 1) Health care in 2020 in the US is not only a health delivery system for its population, it has become much more than that. Our economy has shifted over the last 70 years from primarily an industrial manufacturing economy to a service sector economy. In 2020 health care is the largest segment of the US economy, which is about 18% of our GDP. Technology ranks second at 13%. 2) Being the largest segment of the economy, health care must continue to grow to maintain and improve our GDP — this is the real problem! Despite CMS efforts to decrease the total cost of care by initiating different pay for performance models, total health care costs continue to increase as the number of service sector jobs in the health care industry increase; and 3) magical thinking is required to believe the free market economy can make private insurance health care benefits affordable when the costs for medications, medical equipment, hospitalizations and health care services grow.
As a society we must now think how to best serve our people with the best solution to meet the objectives. In my opinion we need to disassociate health care from the health care industry and let the health care industry and its subsidiaries decide their own path of existence. We need to educate clinicians, patients and politicians regarding our predicament and develop an environment for discussion — health care should not be used for money making, growing jobs or improving the GDP. Government should take the initiative and find innovative ways to finance the cost of health care (the care of people — in 2020 health care in every modern society, including ours, should be considered a fundamental human right) as it does for law enforcement, park services, school education and national security, etc.

Respectfully submitted,
Kalim Ahmed MD FCCP FAASM
Pulmonary/Critical Care/Sleep Medicine
Hagerstown, Maryland

(Dr. Ahmed is a pulmonary/critical care/sleep physician. After graduating from Sindh Medical College (Pakistan). He completed his internal medicine residency at Staten Island’s Richmond University Medical Center (formerly St. Vincent’s Medical Center) and his pulmonary/critical care/sleep medicine fellowship at Jackson’s University of Mississippi Medical Center. Beyond his clinical practice, Dr. Ahmed has significant community leadership responsibilities. He and his family reside in Hagerstown, Maryland.)

Respectfully submitted,
Kalim Ahmed MD FCCP FAASM
Pulmonary/Critical Care/Sleep Medicine
Hagerstown, Maryland

(565 words)

Response to Submission #3 (March 2020)
Editors, I have read Dr. Ahmed’s concerns and concur that our current capitalistic free market system, as he points out, does not seem to be able to control the cost of health insurance or health care services. The only competing universal health systems are the VA and Indian Health Services both of which are underfunded and have had trouble with quality care. The HMO concept reviled by some but championed by many allowed businesses to negotiate a single per person cost for all of its employees or if necessary join with other businesses to form a consortium for better negotiation (thus market system was in place) and then the Insurance company through negotiation (our market system also in play) placed the onus on the best priced economically sound healthcare decisions on the hospital/doctors who should know. If the United States (or perhaps individual states) could negotiate with insurers for HMO plans; could negotiate drug prices; and pay a per person rate, then the large patient volumes begin to regain the original concept/value of insurance as noted by Dr. Ahmed. We could begin to see a reintroduction of a market economy in health care and perhaps more universal coverage.

Stephen F Hightower MD/Geriatric Medicine and Internal Medicine/New Mexico

Editors, in conceptualizing these The HealthCare Papers — Research In Search of an American Health Care System, I envisioned building a consensus for an American health care system one brick at a time. Drs. Ahmed and Hightower have helped me appreciate the wherefore, why and how of a finished skyscraper. Thanking them for
that, I (and perhaps others) will continue to take small bites of the apple while now looking forward to big picture insights.

T Michael White MD/Internal Medicine and HealthCare Value/Florida
#4 Medicare — Not Free — Is an Investment Worth Sharing

Stephen F Hightower MD
T Michael White MD

March 10, 2020

Editors The Healthcare Papers,

Our youngsters (< age 65) are at risk for illness/accident precipitated morbidity, mortality and financial ruin. This risk is no longer limited to those living paycheck to paycheck. The bell now tolls for the healthy, well-educated, hardworking, well-paid, “insured” generations that follow ours. Premiums and deductibles are insurmountable. Our progeny need to be able to opt into a circumstance in which, contributing their share, they are provided with comprehensive, portable, un-cancellable insurance; access to world-class care; protection of life savings; and priceless peace of mind — meaningful, affordable health insurance.

There is some good news. ~60 million Americans participate in Medicare. Those signing up for all Medicare bells and whistles are provided with meaningful, affordable health insurance. But, their Medicare coverage is not free. It requires a thoughtful, disciplined, not inexpensive, investment.

In 2020, for a typical elder the annual investment for a deductible-free plan is approximately $6,500 (Medicare Part B premium $1,800; Medicare supplemental insurance premium $3,200; Medicare prescription drug plan premium $700; and typical prescription co-pays ~$800 = ~$6,500). In a difficult year (Man plans; God laughs), significant drug co-pays could increase this amount. No vision or dental coverage is provided.

For those living in a region where Medicare Advantage plans are available, annual Medicare expenses can be quite reasonable at ~$2,600 (Medicare Part B premium will be $1,800 and typical prescription co-pays ~$800 = ~$2,600). Some dental, hearing, vision and gym services may be included. Should complex care be required, deductibles, etc. may increase expenses to a number quite similar to the traditional Medicare alternative (~$6,500) in a rough patch year.

With these Medicare numbers in focus, our progeny need to be able to opt into a circumstance in which, thoughtfully contributing their share, they are provided with comprehensive, portable, un-cancellable insurance; access to world-class care; protection of life savings; and priceless peace of mind — meaningful, affordable health insurance.

Respectfully submitted,
Stephen F Hightower MD FACP
Geriatric Medicine/Internal Medicine
Rio Rancho, New Mexico

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An Addendum… After years of toil assisted by some good luck, a couple with retirement income and modest accumulated wealth, will gladly stretch to find ~$13,000 (after taxes) for
the comprehensive, portable, un-cancellable insurance; access to world-class care; protection of life savings; and priceless peace of mind provided by Medicare.

Themselves securely covered, should they investigate the circumstance of younger, gainfully employed family members who are living paycheck to paycheck, they will be startled to find: 1) families struggling to pay significant premiums and 2) premiums paid, significant deductibles must be met before coverage begins. A perverse calculus becomes obvious. When healthy, they battle to keep insurance. If accident/illness intervene, unprotected, they are overwhelmed.

How can their industrious, educated and successful near and dear manage accident or illness? Without the protection of immense wealth, they cannot.

This understood, our fine country owes these fine citizens the opportunity to opt into a meaningful, affordable health insurance system.

Respectfully submitted,
T Michael White MD FACP
HealthCare Quality and Safety/Internal Medicine
Belleair, Florida

(Drs. Hightower and White edit The HealthCare Papers)
#5  Logical, Functional, Affordable — COVID-19 Compatible — Health Care

Stephen F Hightower MD
T Michael White MD

March 17, 2020
Editors The Healthcare Papers

As I considered, logical, functional, affordable American health care, the daunting COVID-19 (Coronavirus) pandemic knocked me off my pins. Unexpectedly, my post-concussion period proved lucid. That which I was and am thinking about and trying to say is suddenly not all that complicated.

Somewhere along the line, our fine country’s leadership got to a health care fork in the road, took the wrong turn and ended up and remains lost. The when it happened and who was driving are no longer of import. Getting our country back on a logical, functional affordable health care road is all that matters.

Leadership is entrusted with responsibility for our citizens’ well-being. To accomplish this, our nation’s coffers must support infrastructure (water, power, roads, bridges, trains, airlines; etc.); trade (banking, investing, tariffs, etc.); defense (air, ground, sea and space); public education; security (local and state police; national guard); food security; elder retirement; and, yes, basic health care — care that preserves hearth, home, employment, educations and peace of mind.

What is basic health care? I know it when I see it — an infant with an earache; an elementary student with acute appendicitis; a college student with a psychotic break; a fast-food worker with an infected, impacted wisdom tooth; an athlete with a broken arm; a lady in labor; a truck driver with hypertension and type 2 diabetes; a pilot with sleep apnea; and an elder with pneumonia all qualify. Services that serve the herd qualify too: immunizations; prevention of coronary artery disease; early detection of breast and colon cancers; and preventative dental care. What conditions are not covered? Several of my personal wants (versus needs) fall into that category: hair transplantation; cosmetic surgery and orthodontics.

The rub is finding money in the nation’s coffer for basic health care. As an accountant, I am admittedly a good doctor; however, recognizing the investment is “not a burden but a blessing” (thank you Dr. Jay Stearns — please see The HealthCare Papers #6 below), the calculus is not all that difficult. Anchored in fairness:

1. From birth, each citizen is provided an identifying health care number;
2. From birth, each citizen must pay her/his fair share;
3. Upon entry, each non-citizen guest is given a health care identity and while at risk in our country is charged her/his fair share;
4. Corporations must pay their fair share; and
5. Failure to play fair (for example, working off the books) has significant personal and/or corporate consequences.
Economies of scale, enhanced wellness, negotiated drug prices, eliminated uncompensated care, and freedom from the bankrupting consequences of unmet health care bills will make our nation’s investment palatable and sound.

Our lost leadership has found its wrong way dark, foggy, forest lined, unpaved and without cellular service. Panicked, they have lost compassionate wisdom — citizens’ health is required to ensure all other aspects of community (economy; defense; education; taxes; etc.). We will forgive them for that. However, rescued they must now: 1) appreciate a meager virus has, in mere moments, disrupted national and personal securities and 2) courageously act.

Leaders leading, a health care system can soon be realized. Leaders, enlightened, will provide for innovative public health measures. For example, “on Monday morning at 10 all with health care numbers ending 007, will (happily) present to parking lot AA for their COVID-19 immunization” — a bit reminiscent of efficient fuel-crisis alternate-day fill-ups at the gas pump.

In this post-concussion lucid moment, I am cognizant of an uncomfortable fact — for several decades I have been privileged to more than my share of health and dental benefits while others had none. That understood, going forward, for basic health care I will expect to pay more and expect less so all may be served. Should I desire health care luxuries (immediacy, free valet parking, gourmet meals, private accommodations, award winning architecture), they will still be available to me at a negotiated price.

I can hear the kids (yours and mine) struggling with illogical, non—functioning, unaffordable premiums and deductibles saying, “we’re down with that.” After review, impatient and in a hurry, I am down with that too.

Respectfully submitted,
T Michael White MD
HealthCare Quality and Safety/Internal Medicine
Belleair, Florida

An Addendum… I concur with Dr. White that the health of ALL our citizens’ must be maintained if we are to maintain all other essential aspects of our community: infrastructure; defense; education; economy, and security. As we reach and attain universal health there will be secondary gains on social determinants such as improved housing, better food distribution, and wealth security that will provide for an even greater positive effect on health.

Once we have a common stable health environment, our ability as a nation to promote better environmental health will positively impact our planet — for current and future denizens.

As a nation we have accomplished massive, unfathomable undertakings in the past: The 1930s Great New Deal; The 1960s Reach for the Moon; Medicare and Medicaid in the 1960s; The International Space Station in 1998; and, the vaccine for the Ebola Virus in 2019. Let us do
our fine country proud and realize the unfathomable — a universal health system for our citizens and its more than welcomed guests. Let us step up to our privilege (our responsibility) and lead the world in the science of and access to compassionate health care.  

Respectfully submitted,
Stephen F. Hightower MD FACP
Geriatric and Internal Medicine
Rio Rancho, New Mexico

(Drs. Hightower and White edit The HealthCare Papers)
#6 Single Payer Health Care — A Blessing

Jay Stearns MD
Stephen Hightower MD

March 24, 2020
Editors The HealthCare Papers,

Stimulated by Dr. Kalim Ahmed’s submission #3 Health Insurance — The View from the Trenches, I am pressured to contribute a few thoughts...

A government run health system has been effective in all other first world countries. In fact, according to multiple studies, we spend twice as much per person on health care as any other first world nation but our overall life span, general health and infant mortality are less than that of all industrialized countries that have a single payer system. Despite our enormous expenditures, 37 million people in the USA have no insurance coverage and 41 million people are underinsured leaving them open to financial ruin should they become seriously ill.

The current lack of coronavirus testing in the USA is an example of why the privatization of health care does not benefit the public. In Australia, suffering some mild flu-like symptoms, Tom Hanks and his wife simply entered a walk in clinic and received a rapid, inexpensive, accurate test for the virus and were told they were positive so they could act accordingly. In some countries you can drive up to a clinic window and receive the test. In contrast, the executive branch of the American government has contracted a private laboratory to produce coronavirus test kits. The result — a complex test widely unavailable when needed most.

One must ask, why is there so much resistance on the part of our government to implement such a single payer plan?

The answer to the above question becomes very clear upon consideration that the combined yearly profits of the pharmaceutical and private insurance industries is estimated at 3 trillion dollars per year. These corporations and those like them, spend large sums of money to 1) finance the elections of politicians that will support their agendas and 2) gain control of the media. Thus, only widespread awareness of the situation can end the acquisition of huge profits at the expense of the general public. Hopefully, pens mightier than swords will prove more potent than the corporate influence on our political system.

No system is perfect. Even if a perfect system did exist, human nature would somehow intervene to complicate things. Single payer systems come at a price — not really a burden but a blessing. Plato stated that futile care is akin to insanity. Rather than spending a fortune during the last 6-12 months of a person’s life on futile care, which in most cases amounts to a prolongation of the dying process, the funds would be better spent on disease prevention as well as widespread education (as ignorance is a disease in its own right). Futile care, which is unique to the American health system, also amounts to huge profits for the privately run health system. Physicians in New Zealand, Australia and Canada as well as others, consider such practices not only wasteful but ethically barbaric.
A single payer health system is more efficient, less costly and would blessedly eliminate burden on individuals in this already overtaxed society. It will only be obtainable if the public is informed enough to demand that their elected representatives take control of our health system from corporations — replacing a motivation for (detrimental to the wellbeing of our general public) profit with a motivation for safe, timely, efficient, effective, equitable compassionate patient-centered care for our citizens and guests and to the benefit of our economy.  

Respectfully submitted,
Dr. Jay Stearns
Internal Medicine and Hospitalist Medicine
Indian Health Service (locum tenens)/New Zealand

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An Addendum… I share Dr. Stearns concern about the possible overaggressive medical treatment for the elderly. A recent Cleveland Clinic article identified that 20% of patients admitted to Intensive Care Units were age 85 or older. These critical care beds are typically in high demand due to the lifesaving interventions that are now routinely performed. For each bed, a very high number of nurses and other medical personnel are also required to care for each patient.

The question of what constitutes excessive care is challenging to answer due to so many variables; however, age alone is not felt to be a good barometer. As a geriatrician I do observe that the physiology of most patients is strikingly different at age 85 versus at the age of 75-80. The progression of sarcopenia (loss of muscle mass with associated weakness), imbalance, hearing loss, visual changes, cognitive slowing, immune dysfunction, bone loss, urinary challenges, loss of pulmonary/lung volume, sleep disruption and unfortunately polypharmacy, are quite prevalent. These physiologic changes result in multiple ailments that are not well treated and produce recurring infection, injury, or general dysfunction.

Patients in some states have an option to consider Aid In Dying. This option is for patients with constant pain or advanced physical dysfunction, who typically have a progressive disease process with less than 6 months to live and are cognitively intact. In nine states, CA, CO, D.C., HI, MA, NJ, OG, VE and WA, patients can request assistance with Aid In Dying, which provides the alternative of an oral lethal dose of medication which the patient self-administers. This comes into play when patients have failed to be comforted despite extensive palliative and/or hospice care. Specific requirements are appropriately stringent: multiple requests, both verbal and written are required; two physicians must concur; the patient as mentioned must be competent; and a waiting period must be satisfied.

In our country, there is a disconnect between patients’ perceptions and our medical professions’ practice. While 67% of Americans favor this alternative, only a minority of physicians participate. Less than 1% of physicians in Oregon and Washington State write
prescriptions for Aid in Dying drugs. In the Netherlands and Belgium where this opportunity has been allowed for some time, 60% of physicians have written for such medications. In 2017, 27 states introduced the concept of Aid In Dying and all failed to pass the measure.

Helping our elderly patients live full lives through good diet, exercise, cognitive stimulation, socialization, preventative medical care, and stable, safe living environments is what we will all want as we age. That realized, death will be a part of life. Sometimes a prolonged end to a good life can be tortuously undignified. For some, Aid in Dying will add value and peace for a good life well lived. 460 words

Respectfully submitted,
Stephen F Hightower MD
Geriatric and Internal Medicine
Rio Rancho, New Mexico

(Dr. Jay Stearns has had the expertise and courage to dedicate his practice (in locum tenens) overseas and on Indian reservations — where perhaps others fear to tread. His chosen path has provided his family and him with “a unique view of the world and the human condition.” Dr. Hightower edits The HealthCare Papers)
Good news — our healthcare system has promoted you. You are now your primary care doctor.

Once recovered from incredulity, please provide the unique and very special patient entrusted to you safe, timely, efficient, effective, equitable (just) compassionate care.

For your annual visit with your personal physician (now your primary consultant) or perhaps with your urgent care specialist, you must have your medical record duck’s in a row. As you present, a concise document (two pages max) carefully created by and recently reviewed by Dr. You must be at your fingertips and convey your:

- Name and date of birth;
- Career (proudly describe the person presenting for care);
- Assigned healthcare surrogate (who may speak on your behalf if/when you cannot);
- Allergies and implanted devices;
- Attention to prevention (colonoscopy; mammogram; immunizations; etc.);
- Active medical problems;
- Resolved significant medical problems;
- Medications (regularly taken) and therapies (regularly utilized;
- As needed medications and therapies; and
- Physician Specialists, Preferred Hospital; Dentist, Optometrist; Therapists, Pharmacy and a contact number for each.

In a separate folder (only to be opened upon request), you must have highly selected reports (for example, MRI of your cervical spine; cardiac catheterization; mammogram; lipid studies; etc.) that can be made available to your brilliant primary care consultant upon request.

With this concise, accurate and legible information in hand, your brilliant primary consultant will be positioned to provide you safe, timely, efficient, effective, equitable (just), compassionate patient-centered care (STEEEP). Your efforts, enabling efficient, effective care, will be greatly appreciated (you will be loved for it).

Respectfully submitted,

Stephen F Hightower MD
Geriatric and Internal Medicine
Rio Rancho, New Mexico

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An addendum... As a getting-on-in-age internal medicine physician going to see my superb primary-care physician (now my primary consultant) for an annual visit, I heeded the
above advice. Preparation required an investment of several hours. A tool/gift example of my effort *(My Unique and Very Personal Medical Record)* follows below. The undertaking proved to be time well spent. Organized and informed (remembering details such as expired tetanus protection, an overdue colonoscopy, and a question about the new shingles vaccine, etc.) my good doctor was positioned to provide me safe, timely, efficient, effective, equitable (just), compassionate patient-centered care (STEEEP). What may have taken several visits, was accomplished in one visit saving time, energy and saving several co-pays. My immunizations and cancer prevention were efficiently addressed. My medications were reviewed, improved (yes, less is more) and approved (ordered). A new complaint was considered, diagnosed and treated. Whew!

At the visit's conclusion, my doctor took/had a moment to share — my efforts had converted “hunt and peck electronic medical record (EMR) chaos to calm.” They had made for “a better day” for physician, staff and legions of still to be seen patients. As predicted by Dr. Hightower, I was pretty much “loved” for my organizational efforts.

With that experience behind me, I can see how important my efforts will be should I (God forbid) be required to seek care in hectic, chaotic urgent/emergent care circumstances.

Respectfully submitted,

T Michael White MD

HealthCare Quality and Safety/Internal Medicine

Belleair, Florida

*(Drs. Hightower and White edit The HealthCare Papers)*

Tool/Gift example *My Unique and Very Personal Medical Record follows below...*
Tool/Gift — My (Unique and Very) Personal Medical Record

Thomas Michael Example  Personal and Confidential  April 04, 2019

My (Unique and Very) Personal Medical Record

My Identification:
• Thomas Michael Example MD; DOB: ##/##/####
• Paradise Bay; 555-555-5555; mikeexamplemd@zmail.com
• Career: physician, educator, executive, consultant, author, radio host, golfer and legend in own mind
• My HealthCare Power of Attorney: Ms. Jacquelyn F Example (spouse); Paradise Bay; 555-555-5555
• My Preferred Hospitals: Paradise Bay Hospital and State Capital Regional Medical Center
• Paradise Bay Hospital My Chart Patient Portal: https://www.mychart/patient-portal/

My Allergies/Implants/Prevention:
• Lifetime history of allergic rhinitis
• ACE inhibitors (for example, captopril) cause me to cough
• Respiratory depression with procedural sedation and analgesia
• No known allergies to medications; No known allergy to latex
• Cervical spine (C3-5) plate (titanium) and gel disc spacer placement. No other implants (for example, hip; knee; pacemaker)
• Prevention: Influenza (2018); Pneumovax (2011/2016); Tdap (2009); Pneumovax 13 (2015); Zoster (2009); Hepatitis B (1995); cardiac (cath) 2015; gastroscopy (2017); colonoscopy (2010); AAA Ultrasound (2016); PSA (2017)

My Chronological Problem List:

Active
• 1952 allergic rhinitis — active
• 1978 actinic keratosis and removal of multiple basal cell carcinomas — active
• 1978 gastroesophageal reflux disease (GERD) — active
• 1995 hypertension — active
• 1995 intolerance to ACE Inhibitors (cough) — active
• 1998 rosacea — active
• 2003 cystoscopy and partial prostatectomy for benign prostatic hypertrophy — active
• 2005 low HDL cholesterol — active
• 2013 sleep apnea — active
• 2014 coronary artery disease — active
• 2014 left trochanteric bursitis; left sciatica (L5/S1); left cervical radiculopathy — active
• 2018 cervical spine stenosis — active

Resolved
• 1961 appendectomy — resolved
• 2005 left inguinal hernia repair — resolved
• 2006 hemorrhoid surgery — resolved
• 2011 pre-diabetes — resolved
• 2018 cervical spine laminectomy and fusion - resolved

My Medication and Therapies List:
1. Metronidazole topical cream; 0.75%; each morning (for rosacea)
2. Fluticasone nasal spray; 50 mcg; each morning (for allergic rhinitis)
3. Claritin (loratadine); 10mg; by mouth; each evening (for allergic rhinitis)
4. Lipitor (atorvastatin); 20mg; by mouth; each evening (for hyperlipidemia/coronary artery disease)
Thomas Michael Example   Personal and Confidential   April 4, 2019

5. Aspirin; 81mg; by mouth; once daily each evening (for hyperlipidemia/coronary artery disease)
6. Prilosec (omeprazole); 20 mg; by mouth; each evening (for reflux/indigestion)
7. Cozaar (losartan); 100 mg; by mouth; each evening (for high blood pressure)
8. CPAP; Nasal pillows (medium); 7cm water; 3.5% humidity (for sleep apnea)

If needed medications:
1. Virtussin (guaifenesin/codeine phosphate) AC Syrup; three teaspoons (15cc); by mouth; if needed for severe cough (rarely used)
2. Tylenol (acetaminophen); 1000 mg; by mouth; every eight hours if necessary for aches, pains or fever (rarely used)
3. Advil (ibuprofen); 400-600 mg; by mouth; twice daily if necessary for activity related pain (rarely used)

Note: as you construct your list, please remember to include: medications/therapies for: Behavioral Health Conditions (for example, depression or anxiety medications); Bowel Hygiene (for example, constipation); Ophthalmology Conditions (for example, glaucoma drops): and Pulmonary Conditions (for example, COPD inhalers).

My Pertinent Family History

My paternal grandfather who died at 87 suffered with late life depression. My maternal grandfather died with senile dementia (74). My maternal grandmother died of renal cell carcinoma (85). My father died at 89. He struggled with hypertension, minor strokes and anxiety/depression. My mother is a breast cancer survivor and is alive and well (95). My siblings and children are alive and well.

My Personal Physicians/Care Givers:

• Cardiologist: Dr. Chester Paine/Paradise Bay/555-555-5555
• Dentist: Dr. Floss Daily/Paradise Bay/555-555-5555
• Dermatologist: Dr. U. V. Light/Paradise Bay/555-555-5555
• Gastroenterologist: Dr. Colin Reddy/Paradise Bay/555-555-5555
• General Surgeon: Dr. G. B. Stone/Paradise Bay/555-555-5555
• My HealthCare Power of Attorney: Ms. Jacquelyn F Example (spouse); Paradise Bay; 555-555-5555
• Interventional Cardiologist: Dr. Stent Thrombosis/Paradise Bay/555-555-5555
• Primary Care Physician: Dr. Wm. Osler Nodes/Paradise Bay/555-555-5555
• Orthopedist: Dr. Cairo Practer/Paradise Bay/555-555-5555
• Optometrist: Dr. Venus Blind/Paradise Bay/555-555-5555
• Pharmacy: Dr. Phil Counter/Cornor Drug Emporium/Paradise Bay/555-555-5555
• My Personal Professional Patient Advocate (My P3A): Nurse Grace Wisdom/ Paradise Bay/555-555-5555
• Neurosurgeon: Dr. H.I. Express/Paradise Bay/555-555-5555

My HealthCare Documents (available upon request):

• 2016 and 2017 cardiac cath report; most recent; EKG; latest lab studies
• 2017-01-11 My (Unique and Very) Personal HealthCare Desires and Wishes
• 2014-01-05 My HealthCare Advanced Directives

My Chief Complaint (my story — why I am here today):

Note: for anticipated appointments, I will be prepared (in writing) to discuss the “O-P-Q-R2-S-T” of today’s encounter: onset (when it started); place (what part of body); quality (what it feels like); related symptoms; radiation (where it travels to); severity (scale of 1-10); and triggers (what causes it, makes it worse or makes it better) — after Dr. Orly Avitzur/Yale and others.

From: Safer Medical Care for You and Yours — Six Tools for Safe, Effective Compassionate Care
Stephen F Hightower MD FACP and T Michael White MD FACP
Understandable and Explainable End-of-Life Desires and Wishes

Stephen Hightower MD FACP

T Michael White MD FACP

Sunday, April 5, 2020

Editors The HealthCare Papers,

Our Matriarch, whose age now rounds to 100 years, called. Her request/order was to please, “1) have my unique and very personal health care desires and wishes; 2) in language I can understand; 3) in language I can explain to others; 4) at my fingertips by sundown.”

Message clearly conveyed, she continued by managing-up this physician, “my son the doctor, I do not want you to tell me what to do. I want you to show me yours so I may consider and modify them to my specifications.” And, towards the further advancement of my clinical skills, “doctor cease telling patients what to do. Show them how to do it.”

Our Good Lady, at peace with and comfortable with the thought of an end to life, had her ducks in a row. She had designated her Health Care Power of Attorney(s)/Health Care Surrogate(s); she had alerted them; they had agreed; and she had discussed her healthcare desires and wishes with them. Now she wanted to double down on that discussion. She wanted her desires and wishes in writing, “so the saying and the hearing were in synch.” As requested, I shared my own thoughts (my document) with her:

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My (Unique and Very) Personal HealthCare Desires and Wishes

Two very special individuals in my life have been thoughtfully chosen and have agreed to be appointed my Health Care Power of Attorneys/HealthCare Surrogates. I thank them for that. As important:
• They have given me permission to share my considered thoughts about my unique and very personal desires and wishes for the end of my life with them; and
• They have spoken with me to clarify the meaning of my desires and wishes with me. That done, they are prepared to speak for me should I lose the capacity to speak for myself as they understand...

Provided the wonderful meticulous compassionate care that has been afforded to me over the years, at this time I enjoy good health and I very much enjoy my life.

If I were to unexpectedly become seriously ill and there were to be a reasonable chance for my recovery, I wish to receive all indicated treatment to advance my recovery.

At the same time:
• I comfortably recognize death as a part of life.
• If a meaningful recovery were to be deemed unlikely, I would prefer a dignified death.
• For emphasis and clarification, I would place no value in preserving my life if heart, lungs and kidneys function but my wits, as I now know and enjoy them, have departed.
• For emphasis and clarification, very specifically, if two qualified physicians using an approved protocol determine that I am brain dead or in a persistent vegetative state, please recognize that I have died and proceed accordingly. In such circumstances, I place no value in preserving my life and therefore I desire interventions to maintain my life (for example, feeding tubes, antibiotics, transfusions, ventilators, dialysis, etc.) not be implemented or, if already implemented, be withdrawn.

• For further clarification, I would recognize a prolonged existence in such a state as a major terminal indignity to a life well lived — an indignity to be avoided.

Respectfully submitted,
T Michael White MD
Belleair, Florida
2004-04-02

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Our Matriarch thoughtfully considered my document and asked that I prepare an exact copy for her observing, “Essentially my living will states, ‘if you want to know what to do, ask me. If I cannot speak for myself (i.e., have lost capacity), ask my Health Care Power of Attorney/Health Care Surrogate who will accurately speak for me.’” Then she directed an addition:

• At the same time, should I desire “not to be resuscitated.” I request that this not be interpreted as “not to be cared for.” I request, in every circumstance (recovery or terminal), that my healthcare team continuously attend to my dignity and ensure my comfort (for example, relief from pain and/or shortness of breath). Confidence that my dignity and comfort will be addressed is very important to me. This stated, reassured, I am at peace.

*****

As I created her document, recognizing a significant omission, I went back and updated my own to include, verbatim, her wisdom. Yes, the more I see the process through patients’ eyes, the more complete a physician I become.

At day’s end, her explainable and understandable My (Unique and Very) Personal HealthCare Desires and Wishes were at her fingertips. With two (hers and mine) and counting souls at peace, the world was a better place.

Respectfully submitted,
T Michael White MD FACP
HealthCare Value (Quality and Safety)/Internal Medicine
Belleair, Florida

(Dr. White edits The HealthCare Papers)

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An Addendum... For over 20 years I kept a large picture of Lou Gehrig giving his 1939 farewell speech at Yankee Stadium in one of my exam rooms. Though many assumed I was a Yankees fan, I would clarify that I was not. I was a fan of a man, recognized by his peers and millions of fans as one of the true stars in baseball, who would retire at age 36 at the peak of his game because of a lethal disease.

Conversation started, I could easily segue into a discussion with them about advanced health care directives. The reality is that none of us know when our life might end. The alarming, totally unforeseen consequences of the pandemic which now exists emphasizes that we must be prepared.

Prepared, from my perspective, I had my patient write down advanced health care directives — directives that appoint someone as health care power of attorney/surrogate who will clarify desires at the end of life if my patient is no longer able to speak on her/his own behalf.

Dr. Whites’ example above consists of both a written document to identify a person authorized to speak on behalf of another and initially spoken and then written information about potential life-ending scenarios. This same example reveals how one can patiently and clearly explains to his/her health care power of attorney/surrogate how he would approach the end of his life and, therefore, how he desires his surrogate(s) communicate his wishes. His example clearly includes the spirit of his wishes more than technicalities. In so doing, he is directing his surrogate(s) as to what hard decisions he wants made on his behalf. This is much different that asking a surrogate to use best judgment if/when the time comes. This is important for three reasons: 1) Dr. White has confidence his desires and wishes will be implemented; 2) his surrogates are confident with their (hard) decisions; and 3) most importantly, 3) surrogates will be left at peace with their (hard) decisions. Too often, surrogates, with responsibility clear, are given inadequate direction and are left with lingering doubts regarding their well-intentioned (hard) decisions.

Many healthcare groups have forms to try and help their patients identify a specific health care power of attorney as well as forms to indicate their unique healthcare wishes such as: efforts to prolong life; types of procedures they may or may not want; whether to provide CPR or not; possible organ donation; and hospital or home based care for terminal disease (interestingly on national surveys 80% of people would like to die at home but only 20-30% actually do). I encourage all (yes I have) to today take available forms or Dr. White’s example and clarify desires and wishes.

Do not blindly trust the medical system will do what is best for you. Without guidance, the “better angels” that care for you will be unable to approach challenging issues from your very unique perspective. Their most reasonable decisions made may be very different than yours wishes and desires. Despite the medical systems best intentions, clinical, financial and interpersonal consequences contrary to your desires and wishes may evolve.
As you come to embrace the inevitable reality of mortality, please document your health care power of attorney and the spirit of your desires and wishes in writing today.

550 words

Respectfully submitted,
Stephen F Hightower MD FACP
Geriatric Medicine/Internal Medicine
Rio Rancho, New Mexico

(Dr. Hightower edits The HealthCare Papers)
Introduction

In frantic COVID-19 encumbered today, many resources (for example, medical supplies, food, paper goods) are being carefully rationed. Searching for viable medical budgets (affordable health care), age-related medical rationing has become the subject of an ongoing debate. Though someone at the Beatles’ age 64 (at the time thought to be quite elderly) would not likely be at risk for the withholding of medical treatment, a person at age 84 just might be.

To explore age-related medical rationing, *When I’m 84* will be submitted as three separate opinion-editorials:
- Part 1: The Challenge of Progressive Disease in the Elderly;
- Part 2: The Cost of Health Care for the Elderly; and

**Part 1: The Challenge of Progressive Disease in the Elderly**

The progression of diseases acquired at a younger age or the onset of new medical problems in the elderly creates a very challenging situation for physical independence and functional cognitive capacity. Interestingly, much of the decline in function in multiple organ systems is due to the natural aging process, which places the elderly at significant risk when disease development or progression ensue. This decline occurs even in those who maintain excellent personal habits (diet, exercise, and maintenance of a safe environment) — who at age 80 may be recognized as “the new 60.”

As we age, the lung airways become reduced in size due to alterations in connective tissue. The sacs that exchange oxygen and carbon-dioxide become smaller. The chest wall becomes stiffer. Arthritis in the joints which allow the chest to rise and fall inhibits movement. The diaphragm and the muscles between the ribs atrophy to a 25% reduction in strength. This helps to explain why it is that even “healthy” elderly, with no previous exposure to cigarettes or other respiratory toxins, are at a much higher risk from COVID-19. They no longer have lung reserve capacity on which to draw.

By age 65-70, this intrinsic loss of function is similar for all organ systems and it progresses with age. Heart muscle cells decrease in number causing the heart to stiffen. Increased pressure in the heart results in congestive heart failure. Blood vessels stiffen causing hypertension. Both types of the immune system’s white blood cells decrease in function and increase susceptibility to infections. In addition, the chance that the immune system might
attack normal tissues is increased. Thus diseases such as rheumatoid arthritis may increase. Fluid balance is altered by both a decreased perception of thirst and a decreased ability of the kidneys to concentrate urine. Urinary tract infections become common. Muscle volumes decline. Without muscles to burn sugar, diabetes becomes more prevalent.

Of the 10 major disease processes identified by the National Council on Aging, current disease prevalence in the elderly are reported: hypertension 58%; elevated cholesterol 47%; arthritis 31%; coronary artery disease 29%; diabetes 27%; chronic kidney disease 18%; heart failure 14%; dementia 11%; cancer 11%; and chronic obstructive pulmonary disease 11%. Eighty percent of those 65 or older have at least one, and sixty-eight percent have two of these major disease processes.

Specific data (resource) demonstrating the expected progression of challenging medical problems in the ever-growing elderly population includes:

- Cancer incidence increasing from 17 million persons in 2020 to 27 million in 2030, with those >65 having an 11% higher incidence than other age groups;
- Alzheimer’s dementia will affect 115 million people by 2050;
- Falls will increase, with one of three adults >65 experiencing a fall. 20-30% will suffer moderate to severe injuries resulting in decreased mobility and decreased independence. The 350,000 hip fractures in 2000 will double by 2050;
- Obesity is projected to remain epidemic even in the elderly. The Medicare program will pay 34% more/year for obese patients than for those without obesity; and
- Diabetes will increase from 30 million in 2020 to 46 million in 2030, with 14 million – or 25% of the total being baby boomers.

Aging healthfully is a wonderful gift. Conscientious efforts to maintain a healthy diet, good exercise, restorative sleep, meaningful social interaction, and modestly challenging mental stimulation do result in a greater likelihood of delayed disease onset. However, as noted, just reaching the age of 65 will have produced significant physiologic changes. By 85, major age-related changes result in the vast majority of Americans becoming frail, physically imbalanced, mildly cognitively challenged, visually impaired, hearing deficient and modestly weak. In addition, these aged American citizens are socially challenged — they daily confront uncertainties regarding safe housing, safe transportation, adequate food, home assistance/supervision, and social isolation.

Our search for a viable budget must tackle physiologic certitudes, social realities and economic feasibilities. The process is complex; and to date, unaddressed. Fairness will dictate decisions that will both provide respectful care for our elderly and preserve opportunities for future generations.

Please look for two submissions to follow:
Part 2: The Cost of Health Care for the Elderly in the United States; and
Respectfully submitted,
Stephen F. Hightower MD FACP
Geriatric and Internal Medicine
Rio Rancho, New Mexico

(Dr. Hightower edits The HealthCare Papers)

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An Addendum... OK Dr. Stephen, I get it. Even with replacement parts, I’m not going to live forever. That said, I do not wish to live forever. My wish is for a healthy, productive life span. Recognizing that death is part of life, once health and productivity have abandoned me, I will be comfortable to, with dignity, explore the hereafter.

As a physician with significant miles on his odometer (age 73), I closely observe strangers, patients, associates, friends and family. My experience demonstrates that a reasonable target for planning is 80 healthy, productive years. A few personal caveats:

- Fate (accident/illness) may tragically take me too soon (man plans; God laughs);
- My 80 healthy, productive years may require the intervention of a modern miracle or two (a hip; knee; stent; bypass, etc.). As the kids say, “I am down with that;”
- At age 80, my personal physician, astounded, may (unlikely as I am a very high mileage 73) say, “Doctor Mike, you are a freak of nature. Physiologically, healthy and productive, you are a mere 75.” Should this happen (yes, some of my aging paradigms have reached 90 yet are not quite physiologically 80), I reserve the right to extend my warranty a year or two;
- I do not fear eventual death; however, for the moment, healthy and productive, I do not wish to die now. I have humble work to do (Research In Search of an American Health Care System). Therefore, I fear death by COVID-19;
- Telling the truth, I do fear the onset of dementia. I cannot ethically perceive a healthy, non-productive existence as an ethical use of precious resources. At the same time, I do not understand feasible interventions — this remains a personal work in progress; and
- For me, the end of health and productivity represents a business proposition. Health and productivity lost, I cannot ethically perceive bankrupting my family/society to support brief or prolonged, inevitable decline. Those precious resources are there to support higher callings — the preservation and advancement of healthy, productive lives.

Interestingly, I jumped from Dr. Hightower’s gentle, general discussion of aging health to my own very personal perceptions. After review, that is telling as for us all it is a personal matter isn’t it?

Having the privilege (health and productivity too) to humbly embark on the serious advancement of safe, timely, efficient, effective, equitable (just), compassionate patient-centered care, I am required to share my personal perspectives. It is my responsibility. As you
understand and forgive me, please recognize that you too have responsibility to share your perspectives — what is right? What is wrong? What is being omitted?

Respectfully submitted,

T Michael White MD FACP

HealthCare Value (Quality and Safety ÷ Costs)/Internal Medicine
Belleair, Florida

(Dr. White edits The HealthCare Papers)
#10 When I’m 84 Part 2 — The Cost of Health Care for the Elderly

*Stephen Hightower MD*
*T Michael White MD*

Sunday, April 26, 2020

*Editors The HealthCare Papers,*

“Will you still need me, will you still feed me, when I’m 64?”

**Beatles**

**Introduction**

In frantic COVID-19 encumbered today, many resources (for example, medical supplies, food, paper goods) are being carefully rationed. Searching for viable medical budgets (affordable health care), age-related medical rationing has become the subject of an ongoing debate. Though someone at the Beatles’ age 64 (at the time thought to be quite elderly) would not likely be at risk for the withholding of medical treatment, a person at age 84 just might be.

To explore age-related medical rationing, *When I’m 84* will be submitted as three separate opinion-editorials:

- **Part 1: The Challenge of Progressive Disease in the Elderly**;
- **Part 2: The Cost of Health Care for the Elderly**; and
- **Part 3: The Debate About the Rationing of Health Care**.

**Part 2: The Cost of Health Care for the Elderly**

Considering the cost of care as it is currently provided to today’s elderly can be enlightening.

Multiple statistics help us understand the cost of caring for the elderly. Perhaps most important is that Medicare will become insolvent (meaning it cannot pay for all of its costs, based on current trends) by 2026. That will mean that the elderly will no longer receive complete payments from their Medicare Part A insurance, which currently covers their hospital bills, skilled unit stays, home health costs, and/or out-patient renal dialysis. Other data reveals the following:

- Average yearly health care cost in 2010 for patients beyond age 65 was $18,500; five times that of children, at $3,600; and three times that of working age individuals, at $6100;
- Medical expenses for the elderly doubles between ages 70 and 90;
- Medical costs at age >90 exceeds $25,000 annually;
- Medical spending over the last year of life averages $60,000. These costs represent a quarter of the entire Medicare budget;
- US population 85 and older is growing faster than the working population;
- US Census Bureau predicts that in 2050 84 million people will be 65 or older – twice the number in 2012; and
• In the last six months of life, the average number of doctor visits is 25; 50% visit the ER at least once; 33% are admitted to an ICU; and 20% have surgery.

Recognizing these progressive challenges to the cost of health care, many citizens are practicing the least expensive and most productive method of reducing the volume and cost of health care in the future, which is prevention. They partner with their doctor who:
• Coaches lifestyle habits (diet, exercise, smoking, alcohol, illicit drug use, sleep);
• Keeps immunizations current;
• Encourages and provides prophylactic/prevention measures (mammograms, pap smears, colon cancer screening, aortic aneurysm screening, lung cancer screening);
• Monitors for depression, anxiety, hypertension, and weight changes; and
• Scans blood work for signals of early onset of disease.

Prevention is the most important strategy we have to lower costs and make health care affordable. Not surprisingly (and most importantly), the healthiest 50% of Medicare patients represent only 3% of total health care costs. However, prior to reaching Medicare coverage (age 65) the opportunity for prevention is challenging for the 80 million uninsured/underinsured Americans who cannot begin to consider paying costs, co-pays or deductibles for prophylactic testing.

Uninsured/underinsured American citizens have an exceptionally high risk of acquiring one or more lifestyle-related diseases. They endure the added risk of not receiving appropriate medical screenings or immunizations. They are unlikely to benefit from detection of diseases that could be treated much more effectively and efficiently (less expensively) in earlier stages. Much of their care is unnecessarily provided by emergency rooms — treatment that comprises one-third of all health care costs in America. Unfortunately, unable to avail themselves of prevention, they are overrepresented among the 5% of Medicare patients who consume 50% of Medicare costs.

As citizens age, the cost of care will increase. By not caring for young people, opportunity is missed for identifying, addressing and ameliorating life impacting medical issues. By not caring for young people, opportunity is missed for reducing those health care costs.

Then comes the question — what options does society have when it can no longer support elder care. Is some form of rationing of care appropriate? Will rationing of health care start with the elderly? Will we shift from paying for Medicare, which can no longer pay all of its bills, to paying for our uninsured younger citizens? Is Universal Health Care the answer to solving both problems?

A discussion towards an understanding of the debate surrounding the controversial issue of health care rationing will follow in Part 3.

Respectfully submitted,

Stephen F. Hightower MD FACP
Geriatric and Internal Medicine
An Addendum… With insincere apology, as I consider Dr. Hightower’s Part 1 and Part 2, it is again all about me. To wit: getting older; advancing age and gradual decline run hand in hand; daily prevention (starting yesterday) is paramount; and, reasonable expectations about the extent of care that will be consumed near the (inevitable) end of life are in order. Whew!

Without trying to argue away the certainty of the above paragraph, I wish to challenge the notion that appropriate care must be expensive. As an example (just one small bite of the apple), please consider that someone very near and dear to you; is, sadly, not independently wealthy; has approached life (style) judiciously; and is just a few years short of Medicare (and an affordable prescription plan), now requires a second drug for type 2 diabetes.

His brilliant academic endocrinologist chose the “perfect” medication to be added to baseline ($4/month) metformin—Januvia/sitagliptin. After haggling and a touch of coupon magic, the cash price for a month’s supply of sitagliptin was reduced from $600 to $425/month. Despite these considerable savings, family food and housing security would be placed in jeopardy — again, at times “perfect” can be the enemy of good.

Returning to the endocrinologist for an affordable alternative, the following salient points were shared:

- Januvia/sitagliptin was the preferred choice;
- Highly marketed (to public and to prescribers) alternatives ($1,000/month) would have made Januvia/sitagliptin seem affordable; and
- After consideration, an affordable cost-conscious alternative would be generic glimepiride ($5/month).

To address potential hypoglycemia (low blood sugars can be glimepiride’s downside), the specialist started with a low dose, would slowly increase as needed over time (i.e., go low/go slow) and educated the patient about the symptoms of and responses to hypoglycemia.

Posed a similar hypothetical circumstance, a brilliant family physician saw it this way: “I encounter this regularly. My goal is to encourage a healthy lifestyle; maintain blood sugars and HGB A1Cs in reasonable (not overly meticulous) control; and maintain quality of life. In that regard, avoiding overwhelming expense, is a vital consideration. Based on my training and experience, I often add generic pioglitazone ($15/month) to baseline metformin.”

The moral of this story? 9% of Americans deal with Type 2 diabetes. If only 10% of those could save $5,000/year by prescribing practices that balanced clinical and financial considerations: 1) the individual would be in a better place; 2) American health care would have ~$7.5 B (a significant underestimation) for other considerations; and 3) applying such logic to
other common conditions (for example, lipid management) significant savings will allow for increased access to affordable care.

Despite decades of inflation, a billion here and a billion there still equates to real money — money enabling meaningful solutions.

Respectfully submitted,
T Michael White MD FACP
HealthCare Value (Quality and Safety ÷ Costs)/Internal Medicine
Belleair, Florida

(Dr. White edits The HealthCare Papers)
#11 Two Health Care System Quick Fixes — The Consumer and Medical Liability

Mr. Charley David Price
T Michael White MD

Sunday, May 3, 2020
Editors The Health Care Papers,

“Opinions are like noses, everyone’s got one.”
Lou Galliker

I am not the most qualified to submit this opinion-editorial. Nevertheless, circumstances demand sharing of opinions and, having one, I am obligated to proceed.

First, a tangent — I am tired of politicians blaming greedy pharmaceutical companies, greedy insurance companies, and greedy health care providers. We need “Big Pharma” to do the high cost R&D and take the risks that lead to the development of new medicines. We need insurance companies to be profitable, because if they aren’t, there won’t be any insurance. And, we need medical providers to be the best paid professionals in our society, because when our loved-ones are sick, we want highly trained, highly motivated men and women, who have invested their youths and their fortunes in their disciplines, to take care of them.

As you say, this is a complex problem and there are no easy or painless answers. But, I believe there are two issues that are part of the problem, and if addressed, would go a long way toward reducing health insurance costs: 1) the health insurance consumer; and 2) medical liability.

Insured health care consumers treat their health care as if there is no cost — HELLO, IT IS INSURANCE — not a free church buffet. We buy insurance and pay a premium to share risks and avoid a sudden large expense. The premiums have to match some version of the actual cost; otherwise, there will be no insurance. People (myself included) go to the doctor at the first sign of illness or the slightest discomfort expecting medication and testing, even when neither are indicated. If we treated our car insurance like our health insurance, we would be making car insurance claims when our car needed to be washed and waxed. Health care consumers need to understand the purpose of their insurance; change their expectations; and, most importantly, change their behaviors.

Surely you say, medical professionals can police inappropriate expectations and behaviors. Bizarrely, medical professionals are being incentivized by corporate medicine based on feedback (grades) from their patients. After years of training and dedication to the complexity of safe, timely, efficient, effective, equitable (just) compassionate patient-centered care, they are judged by patients, who, with their minds made up by TV ads, internet searches and personal needs, do not want to be encumbered by facts. Imagine a reality — a professional’s compensation is linked to patients’ evaluations — patients requesting antibiotics, opioids, and tests they do not need. Doing the professional, ethical thing, equates to lower evaluation scores and diminished compensation. Instead of synchronous care (satisfaction,
ethics and compensation) disharmony bizarrely reigns. Parenthetically, I so wish this logic prevailed when I struggled with college calculus. Competing for tenure (and requiring my support), Assistant Professor D. A. Gloom’s opinion of my work surely would have better aligned with my targeted GPA.

Drug prices are out of control. Prices are lower in other countries. But, people ignore the liability and mass tort exposures these companies have with these medications. Why aren’t we talking about that? Because most of our politicians are lawyers. Pharmaceutical companies are budgeting for these costs and of course drug prices are going to be high. I wonder if they are budgeting 25%, 30% or more of the prescription price to cover future liability? If we had tort reform in this country, those costs would drop dramatically.

As you know, insane liability issues have been driving doctors into early retirement for 20 or more years. Spend a moment with an early retired obstetrician discussing her/his malpractice premiums and then wonder why when graduating medical school, he/she ever considered obstetrics and gynecology.

To a large degree, we are always identifying the wrong root cause for complex problems. Take the mortgage crisis that occurred in 2007. We’ve all seen the documentary, Inside Job, and the movie, The Big Short. Both went to great Lengths to say that it was evil Wall Street that created the financial crisis. But was it? No, it wasn’t. Sure, part of the story was Wall Street doing what they do. They saw an unbalanced financial situation and figured out how to profit from it. But, the underlying issue or root cause was the Fair Housing Act of 1968 as updated in 1988. Banks were required to make loans to people who had no income and no ability to repay. They were audited by the FDIC and unless 9% of their mortgages fell into this class they were at risk of being fined or shut down.

Finally, I’ve seen a version of single payer healthcare in California, where it takes six months to get an appointment with a specialist. I tried to get one of my plant workers an appointment with a psychiatrist in November and the first appointment available was April 22.

Wherever a new health care system takes us, it must provide for highly trained, highly motivated, highly compensated professionals that are there to care for us.

Respectfully submitted,
Mr. Charley Price
Santa Barbara, California

(Mr. Price writes from his perspective as a food industry president/chief operating officer.)

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An addendum… For the moment, Mr. Price has provided me with a magic wand. Wand in hand, I shall invent an American health care system — yes, déjà vu all over again:
1. Close health care as we know it. Open new program: basic healthcare;
2. Define basic healthcare (cover needs; wants may be purchasable in the marketplace);
3. Recognize basic healthcare as critical infrastructure;
4. Cover all citizens, immigrants and visitors with basic health care;
5. Charge and collect a fair share premium from all citizens, immigrants and visitors;
6. Educate each educible individual to serve as her/his primary care provider who is (with teledicine and local pharmacist) on her/his own for the small stuff;
7. Allow individuals to select their care from competing certified health networks;
8. Have trained professionals scrutinize the work of healthcare professionals (not patients);
9. Through a just process, make the (rare) harmed individual whole;
10. Create an environment where health care professionals work under respectful scrutiny without fear of legal entanglement;
11. Compensate health care professionals well; and
12. Ensure that in short supply health care professionals are incentivized to be productive.

What would this look like for a Mr. Price, for his executive assistant, for a worker in his plant, his self-employed lawn care professional and his unemployable neighbor? With wand in hand and ball crystal clear:

• All would purchase basic health plan insurance from the federal government via individual and/or family plans;
• All would contribute the same;
• “All” would include discharged military;
• The premiums for lower income individuals and the unemployed would be subsidized;
• Pre-existing (basic healthcare) conditions would be covered;
• Individuals/families would choose to receive their care from competing certified federally approved health care networks (primary care; urgent care/telemedicine; emergent care; hospitalization). In consultation with telemedicine nurses and pharmacists, all would function as her/his own primary provider for sniffles, aches and pains. If/when accident/illness intervene, the ill will confidently access their hand-picked health care network;
• Modest co-pays would be assessed for prescriptions, office visits and hospitalizations to incentivize (i.e., ensure skin in the game) judicious behaviors;
• All would have access to their accurate and legible portable electronic personal medical records at fingertips;
• All would have the financial security and the peace of mind afforded by basic healthcare coverage;
• Health care professionals would be free to choose the health care network (primary care; urgent care; emergent care; hospitalization) in which they would practice;
• Health care professionals would be incentivized (salary; educational loan forgiveness; etc.) to practice in under-served environments; and
Recognizing that in America “cash is (and will always be) king,” individual health care professionals can set up parallel fee-for-service practices and individual patients can access (and pay for) offered services.

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What would Mr. Price make of this? I postulate that with a year’s experience behind him, he might observe:

• I have to say I was skeptical;
• The advantage of health care being part of the infrastructure is obvious. With affordable (not inexpensive) insurance, no one has to delay plans (educations, housing, change of careers; etc.) for fear of illness/accident induced bankruptcy;
• Fortunately, in the past year I and mine have been well; however, brief encounters have worked surprisingly well;
• As an employer, although wages have increased to reflect decreases in benefits (and premiums paid by employees), I am happily no longer in the health insurance business; and
• I, with comfortable personal savings, have to consider my options: if/when I have a hip replaced will I use my insured health care network (co-pays ~$200); go to the boutique orthopedic hospital down the street (and pay the freight (~$40,000); or travel to a boutique orthopedic hospital in India (and pay the freight (~$25,000 travel included)? Although my decision is uncertain, I am influenced that $40,000 here and $40,000 there and “soon you are talking about real money.”

Respectfully submitted,

Internal Medicine/HealthCare Value, Quality and Safety

T Michael White MD

Belleair, Florida

(Dr. White edits The HealthCare Papers)
When I grew up, many years ago, we had a wonderful family doctor, Dr. Reilly. To my seven year old self, he was kind, patient, and whip smart. Whenever one of us was sick, Doc would come to us with his little black bag and dole out medicines and lollipops. He knew everyone in my family (mom and dad, brother and sisters) and all about our health. He knew it in the context of our family and our community. But now all that is gone.

Today, families are scattered across the country and around the globe. Few people have relatives who know each other’s health care burdens or triumphs in any detail. Between my husband and myself, we’ve seen more than enough specialists. And our medical records are scattered in multiple offices and on multiple servers. Although we’ve been blessed with good medical insurance, many of my family members have not.

I’ve given some thought to what I’d like health care to be in the future. I hope it’s not wishful thinking.

First, I want health care for everyone, simply because I believe that all life is sacred and deserves the best care possible. Universal health care would help children stay in school, adults live active, productive lives and seniors find more gold in their “golden years.” More than 28 million people in the US are without health care and that takes a terrible toll on their lives — waiting until the last minute to get help, suffering the consequences of chronic disease, facing financial ruin and diminishing quality of life.

We know that decreased access to health care increases one’s chances of living with chronic, debilitating disease. There is no reason why a country as rich and powerful as the United States should allow this to happen to any of its citizens. Providing health care resources to everyone will improve the strength of our society on individual, community, and national levels. I am not a health care economist, so I don’t have the answer about how to provide universal health care, but I strongly believe that we must move forward on this issue quickly.

Second, the patient should be the primary owner of his medical information. Similar to a Social Security Number, each person must have a personal, universal health record number. That number would provide access to all of his personal health care information from all of his providers. Having bits and pieces of personal health care information scattered in medical offices across the country is useless in providing a well-informed picture of the patient’s health status. In Dr. Reilly’s day, it was much easier to know both the patient and his health circumstances. This is not an option today. Now families are spread far and wide with the

“...”}

William Osler
resultant lack of context and knowledge. So we must rely on technology to get us through. We need one electronic health care record (unified in one highly regulated agency) that provides comprehensive information about a particular patient. That way, there is greater continuity of care regardless of who the patient is seeing or where the patient is being seen.

A universal health care record requires three things: a way for health care providers and patients to make corrections, greater technological and health literacy on the part of patients and a “health interpreter” whom the patient can query for a better understanding of the information he finds in his health care record. With accurate, legible, up-to-date information, health care providers will confidently communicate directly with patients. Care, trust and mutual respect will be enhanced.

Third, there should be increased recognition and use of the value of alternative therapies. Because they can provide complementary benefits to patients, they should be offered more regularly. They need to be investigated and accepted more widely by traditional health care providers who should then refer patients to them. To that end, alternative therapies themselves (for example, acupressure/acupuncture, yoga, meditation, hypnosis, biofeedback) must clearly demonstrate that the treatments actually work. While patients are free to seek these therapies on their own, I advocate more professional collaboration between traditional and alternative groups — assisting patients differentiate between “snake oil salesmen” and bona fide health care alternatives.

While I miss the old days, Dr. Reilly, his black bag and his lollipops, I am grateful for the excellent support of the health care providers that I have access to today. I realize that I am privileged. I hope that someday this privilege (access, information and care) will be extended to every individual in this country — bringing a brighter future for all. There is no reason it should not be.

Respectfully submitted,
Ms. Maureen Theriault MA BA
Hagerstown, Maryland

(Ms. Theriault writes from the perspective of a health care editor, a public relations professional, a family care giver and patient)

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An Addendum... The thoughts provided by Ms. Theriault in her contribution “My Hope for the Future of Health Care” are just what we are requesting from all our readers — opinions on what you believe would advance our health care system. Increasingly informed, the search goes on.

Ms. Theriault focuses on three important areas which are of major concern:

• We agree that universal health care is the most important issue we need to address in the United States. As Ms. Theriault notes, life is sacred and all Americans and welcomed visitors should be able to have access to the benefits that lifelong health care can bring.
Some examples of lifelong health care include: childhood immunizations; peri-natal care; early reminders of the adverse effects of certain habits; the encouragement of healthy eating; counseling about exercise and its role in health; prevention; diagnosis and treatment of disease at early stages; counseling about depression or anxiety and other mental health issues; and healthy aging. Universal health care would assist an estimated 40-80 million people who now suffer with no or inadequate health care and provide them an opportunity to maximize their lives and their own contribution to a great nation.

- As Ms. Theriault observes, control of personal health care records is an increasingly challenging problem. In a medical system where so many physicians are independent or in small groups, personally obtaining copies of your individual records is not easy and can often be delayed even at the request of your primary doctor. This is why Dr. White and I have encouraged individuals (see #7 Bulletin — You are Now Your Doctor) to keep a copy of their Unique and Personal Medical Record with them at all times. The growth of multispecialty medical groups, often aligned with a particular medical system, have facilitated the growth of comprehensive electronic health records. These systems allow for accessibility of all out-patient and in-patient care records by multiple physicians as all records are kept in one electronic medical system. These allow the patient more control of their own procedures, records, and general information. Generally these type of records are correctable. And as requested by Ms. Theriault, there are now consultative services available from multispecialty centers who, with your permission, obtain records from multiple evaluations and tests you have had. They can then provide insight with their thoughts about diagnosis and suggestions if other testing might be warranted. One caveat, as soon as you step a block, a mile, a state or a country away from your system, all these electronic health record advantages dissipate.

- Increasing recognition of the effectiveness of alternative therapies was also important to Ms. Theriault. Procedures such as acupressure, acupuncture, yoga, meditation, hypnosis, biofeedback, chiropractic treatment, massage therapy, and pool therapy can have highly beneficial effects in providing relief from multiple symptoms with limited risks. The specific therapies to be covered must be based on good research evidence. Appropriately selected, use of these therapies could help reduce excessive drug use and improve the sense of overall wellbeing in a large portion of the population.

We unfortunately cannot bring back the “old days” — our family doctor making house calls with black bag and lollipops. However, I think medicine can still provide much of the same experience (at an affordable price) if a caring primary care physician... is supported by a helpful, universally available medical system that is current on the best medical and alternative therapies for treating physical and mental disease... is aligned with a motivated patient... who
has her/his Unique and Personal Medical record at fingertips — a national health care program of which the United States and Ms. Theriault can be proud.

Respectfully submitted,

Stephen F Hightower MD FACP

Geriatric Medicine/Internal Medicine

Rio Rancho, New Mexico

(Dr. Hightower edits The HealthCare Papers)
#14 When I’m 84 Part 3 — The Debate About the Rationing of Health Care

Stephen F Hightower MD FACP

T Michael White MD FACP

Sunday, May 17, 2020

Editors The HealthCare Papers,

“Will you still need me, will you still feed me, when I’m 64?”

Beatles

Introduction

In frantic COVID-19 encumbered today, many resources (for example, medical supplies, food, paper goods) are being carefully rationed. Searching for viable medical budgets (affordable health care), age-related medical rationing has become the subject of an ongoing debate. Though someone at the Beatles’ age 64 (at the time thought to be quite elderly) would not likely be at risk for the withholding of medical treatment, a person at age 84 just might be.

To explore age-related medical rationing, When I’m 84 will be submitted as three separate opinion-editorials:

Part 1: The Challenge of Progressive Disease in the Elderly;

Part 2: The Cost of Health Care for the Elderly; and

Part 3: The Debate About the Rationing of Health Care

With the inevitable progression of disease as we age (Part 1); the mounting cost of care as we age (Part 2); and the associated projected insolvency of Medicare in 2026, a perfect storm has formed for societal reevaluation of health care rationing.

Actually, health care rationing is not new to the United States. In her book, Health Care for Some: Rights and Rationing in the United States since 1930, historian Beatrix Hoffman notes that 45,000 Americans die every year because they lack health insurance — revealing rationing of care based on affordability. Dr. Arthur Kellerman, previously professor of Emergency Medicine and Dean for Health-Policy at the Emory School of Medicine, similarly noted that America has always rationed health care on the ability to pay. The United States government rations health care by age with Medicare and assists states in rationing health care by income level with Medicaid. Interestingly, all countries with universal health care systems ration by various techniques such as: controlled distribution through national budgeting; setting of prices and provider fees; and restriction on the utilization of some services based on specific criteria. However, at a minimum, countries providing universal care provide basic/adequate services for all residents (often including visitors and immigrants) of all ages.

This discrepancy in providing basic/adequate care to everyone is based on one concept — countries with universal care believe that health care is a right. United States’ citizens have the right to expect access to clean air and water, police and fire services, sewer disposal, serviceable roads, etc. However, our government has not yet embraced the concept that health care is a right — apart from a right to assistance in an emergency room (which has only
existed since 1986, and only requires stabilization). In a country where inalienable rights are central to citizenship and national identity; where opinion polls have shown broad public support for the concept of health care as a right; and where a pandemic demonstrates a need for universal access to health care, our citizens do not have a right to health care.

Many American citizens die prematurely due to a lack of: routine preventative education and care; affordable professional evaluation and testing; affordable medications; and affordable treatments. Even citizens who (by age) attain Medicare coverage but cannot afford add-on supplemental insurance, add-on prescription drug plans or deductibles and co-pays, cannot bear the uncovered costs for outpatient care, testing, hospitalizations, medications and/or treatments. For them, expectations for participation in preventative health measures are incongruous. If/when care becomes unavoidable (for example, a call to EMS lands a critical patient in the emergency department), uncovered costs first bankrupt the individual and then her/his significant others. Finally, uncovered costs massively burden the medical system.

A discussion of the concept of rationing health care based on age came to the forefront in the book: Setting Limits: Medical Goals in an Aging Society, written by Daniel Callahan in 1987. Dr. Callahan was an ethicist and founder of the Hastings Center, a nonpartisan bioethics research institute in New York. Dr. Callahan advocated for a limit on care based on age and against the provision of extraordinary and expensive medical procedures for those who have already lived a full life. At the time of his writing he pointed to the years 70-80 as being indicative of a full life. It is my personal observation, garnered from 35 years in active practice of geriatric medicine, that 85 years of age is more indicative (though certainly not an absolute) of a “full life.” From that age on, relatively consistent progressive physical and cognitive decline ensue. In Dr. Callahan’s opinion, Medicare should/must be able to determine what benefits/tests/treatments, should be available based on cost and efficacy. In England, The National Institute for Health and Care Excellence (NICE) has been performing these types of evaluation for years. NICE, accounting for age and functional status, assists providers by producing evidence-based guidelines for care of multiple disease processes; provides advice for public health by supplying the quality standards to be provided to patients as well as standards for country-wide social services; negotiates drug prices; and evaluates cost-effectiveness of any drug and any new procedure which is being considered for adoption.

In the United States, the Medicare program is not allowed to evaluate drugs or procedures by cost-effectiveness. It may only determine if they are effective and not harmful. This results in multiple procedures or medications that provide the same benefit. This allows physicians to use more expensive newly approved, surgical treatments, medications, imaging procedures, etc. that often have not been shown to produce more benefit or better outcomes. Insurance companies, on the other hand, may pick and choose what they will cover and attempt to find the least expensive drugs, treatments, radiological evaluations, and surgical procedures.
According to cost and outcomes research in our country, if universal coverage provided access to the best cost-effective treatments and medication available, cost savings would relieve some of the burdensome reality of rationing health care based on any criteria.

If we fail to provide universal care and ignore cost-effective studies, we likely will follow Dr. Callahan’s rationale and experience the denying of hospital admission to anyone 85 or over. Their treatment will be provided at skilled nursing facilities or at home by home, palliative and hospice care nurses.

Elderly patients are often encouraged by their physicians and families to fight cancer, heart disease, lung disease, renal failure, etc., even in the setting of the patient’s frailty, dysfunction, and obvious poor and declining health. Subtle intimations suggest the patient who chooses not to fight is a failure — a travesty for the understanding of a life well lived. Death is not a failure of the patient or medicine. Declining therapy is often more meaningful than the 2, 4, or 6 months of existing in agony and dysfunction due to the progression of the inevitable and/or the side effects of treatment. The patient can be well served when families, assisted by palliative care and hospice, come to grips with the reality and comfort of a gentler movement along the timeline to death.

There is an expectation that science and technology will eventually triumph over sickness and death. We have made significant progress, yet death remains an absolute and unavoidable reality. Dr. Atul Gawande, MD noted, “Our medical system is excellent at trying to stave off death with $8,000 a month chemotherapy, $3,000 a day intensive care, and $5,000 an hour surgery. But ultimately, death comes and no one is good at knowing when to stop.”

Perhaps in the near future, if we as a country cannot agree on universal care, those of us who stay healthy enough to reach the age of 85 will voluntarily participate in Dr. Callahan’s proposal to ration based on age — that is, of course, providing Medicare survives long enough to preserve our choice.

1135 words

Stephen F. Hightower MD FACP
Geriatric and Internal Medicine
Rio Rancho, New Mexico

(Dr. Hightower edits The HealthCare Papers)

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An Addendum...

“I hate the men who would prolong their lives
By foods and drinks and charms of magic art
Perverting nature’s course to keep off death
They ought, when they no longer serve the land,
To quit this life and clear the way for youth.”

Euripides 500 BCE
As darkness follows the gloaming, Part 3 must follow Part 2. Logic and rhythm would have had this courageous opinion editorial published prior to April’s end. Delay has stemmed from addendum paralysis — paresis induced by the challenge of first confronting and then articulating and sharing most-personal, repressed, all too well-knowns. Shambling, I step forward to convey:

1. “Man plans; God laughs.”
2. Required to be pre-purchased (via a tax) basic health care must become a right/obligation for every citizen, immigrant and visitor.
3. Said basic health care requires definition — an odyssey for another day.
4. As a physician, I observe individuals chronologically age 90 who are physiologically and mentally equivalent to 70 year-olds (the new 60). Conversely, some age 70 are functioning as if already 85. *(Painful Personal Truth #1 (PPT #1): at 74, my physiognomy resembles an in need of maintenance high mileage (+/- 300,000) ancient Subaru. Dr. Callahan’s life expectancy guesstimate (~80) feels spot on.)*
5. I was taught (and then I taught), that I must plan/save for 4 goals: my education; my family’s educations; my home; and my retirement. *(PPT #2: this list was short by two.)*
6. Now, I understand that the plan/save goal number is six, to include: my health care and my family’s health care.
7. When I escaped from the protection of my parent’s umbrella, I should have:
   - Funded educations;
   - Purchased health care;
   - Saved for retirement; and when (and only when) these foundational issues were successfully addressed,
   - Purchased housing (and vehicles) compatible with my remaining discretionary income.
   *(PPT# 3: by necessity, health care obligations would have made home and auto decisions decidedly different.)*
8. My tax return should have encompassed:
   - My federal taxes;
   - My state and local taxes;
   - My social security tax (retirement); and
   - My basic health care (individual and family) tax.
9. Should my circumstances have allowed, I would have placed additional funds in a retirement IRA.
10. Should my circumstances have allowed, I might have opted for (surely) available additional health care/prescription insurance.
11. So how does this logic differ from the status quo? *(PPT #4: in my lifetime, I considered basic health care to be my right — a right unfairly not shared by all. Because health care was magically bequeathed to me, I had discretionary income for luxuries.)*

12. What is wrong with being a lucky recipient — a lottery winner? *(PPT #5: proudly being a (handsome), kind, compassionate type incapable of prejudice, my good fortune discriminated against the less fortunate — insentient, I am complicit for the substandard health care status quo.)*

13. OK, so let’s just provide basic health care to everyone and proudly move on *(PPT #6: it may cost everyone, including me, proportionally more. After review, my privileged health care has been underwritten by the have nots. A zero sum game will require modest sacrifice on my (and your) part.)*

14. OK then, let’s just sit back, enjoy the ride and let others worry. *(PPT #7: carefree times have passed. The piper has caught up. Unless protected by immense wealth, our children, having already paid massive premiums still face massive deductibles and co-pays that leave them essentially uninsured. Educations, hearths and homes, treasures and peace of minds are unprotected. We are far beyond trouble free tomes.)*

15. Q: OK, OK. So telling yourself (and us) the personal painful truth, what do you advise? 

**A:** Speaking only for myself *(PPT #8):*

- I am prepared to pay my fair share for my Medicare, which although not inexpensive, does protect hearth, home, treasure and peace of mind.
- I am prepared to be assessed a tax that supports basic, compassionate, safe, timely, efficient, effective, equitable (just), patient-centered care for all.
- My support for such a tax is contingent upon an understanding that genius will strive for and deliver affordable health care value (quality ÷ cost).
- Each day, I will endeavor to make healthful decisions (diet) and actions (physical exercise and mental gymnastics).
- Long term, I will endeavor to utilize health resources wisely. I go forward understanding all (including me) will drive health care VVs (rather than continuing to speed in luxury while others walk on the roadside). Long term, my health care decision equations will factor in care, costs and impact upon family and society.
- I recognize I will not and I do not desire to live forever. *(PPT #9: having run my engine long and hard, my over/under is ~80.)* If/when decline catches up with me (as it will), I will not yearn for breaths and heart beats that do not support a meaningful, productive existence.
- Most importantly, my life will not add to the statistic that demonstrates that massive health care expenditures accrue in the last weeks/months of life. *(PPT #10: having lived life well, I look forward to an efficient ending to a life-well-lived*
that will 1) preserve my dignity and 2) preserve precious resources so that all that follow (family and society) may benefit from basic care.

If this reads too personal, that is because it is and must be too personal. Each of us must personally assess our careers, our decisions, our care and the legacy we will leave to our progeny and to our society (to one another).

Forced by this addendum assignment to review painful personal truths, I better comprehend that I (you and our nation) must begin to walk my (our) kind, compassionate, equitable/just talk. Immediately, through uniform sacrifice, all must be provided basic health care. Although scaled back, lifestyles will remain robust. Health care protected, educations, hearths and homes, treasures and peace of minds will be secure. Security achieved, expected grateful payback (fair-share good citizenship and productivity) will follow. A physically, spiritually and economically healthier nation may be anticipated.

Respectfully submitted,

T Michael White MD FACP
HealthCare Value (Quality and Safety ÷ Costs)/Internal Medicine
Belleair, Florida

(Dr. White edits The HealthCare Papers)
None Are Protected Unless All Are Protected

Dana S Kellis MD PhD FACP
Stephen F Hightower MD FACP

Sunday, May 24, 2020
Editors The HealthCare Papers,

“Give us the tools, and we will finish the job.”

Winston Churchill

I was exhausted, leaving the daily Incident Command Center meeting of a major health system. Seven weeks into the crisis, we had spent another two hours talking, debating, and hand-wringing over which groups of patients, employees, and physicians would be tested, who would be provided what kind of PPE (personal protective equipment), and how we should treat confirmed cases, patients under investigation, high-risk cases, and so forth. No matter how much effort we expend nor how carefully we make decisions, the next day always brings new dilemmas, new demands, new opportunities to save lives, resolve conflicts, and limit the damage of the COVID-19 crisis. This daily test of leadership, intellect, clinical expertise, and organizational management brings to my mind once again the questions: How can we still be here after seven weeks? What should we have done at this time last year to prepare? How can we now be better prepared for the future? The answers are uncomfortable and difficult.

One lesson we’ve learned is that health and health care is not just a personal matter, a community matter, nor even a national matter. My health is connected to the health of every other human on the planet. An illness that started on a street corner ten thousand miles away put my health and the health of those near and dear to me in serious jeopardy.

The second lesson is like the first. How naïve we have been to focus on “American Health Care.” We’ve found that we depend on factories in places like India and China for the things our doctors, hospitals, and patients need, like medications and equipment, as much or more than we rely on the medical warehouses in our own cities and states.

The third lesson emerging from this crisis is that leadership matters. It is embarrassing to realize that our health system is competing not only with the other health systems in our own community, and others from around the country, but we’re also competing even with our own government for supplies and medical equipment. The morning news delivers a daily comedy routine of opinions and decisions with no discernible evidence of collaboration or leadership, a comedy that puts lives and livelihoods at risk.

The fourth lesson is that science matters. The anti-science, anti-knowledge, anti-truth fervor sweeping the globe has needlessly cost the world many lives and will continue to do so until we regain our scientific bearings and make evidence-based decisions as we’ve all learned to do. This lesson extends to health care as well, where we must accept accountability for using toxic, unproven therapies for patients that ultimately were found to do harm and little if any good. We know better.
The fifth lesson is how fragmented we as physicians have become. One of the most frustrating aspects of my life as a physician-leader over the past couple of months has been explaining to my non-clinical colleagues why different specialty societies have published non-evidence based guidelines for their members who in turn demand equipment and supplies that aren’t available, that create schisms and ill will with other health care professionals, and that ultimately undermine the ability of health systems to care for patients and protect staff and physicians.

Fault-finding comes easily as a “Monday-morning quarterback.” Most if not all of us have been doing the best we can with what we have. Regardless, we have a huge opportunity to use this crisis to change the course of medicine, to make health care better and more secure for all of us.

Electronic communications are second nature to more of us than ever before. Let’s use these skills to unite as a profession, to speak with a collective voice of reason and of wisdom and to provide leadership for our local, national and international communities for health-related issues. Perhaps we can empower that voice with our voices and efforts to convince governments to dedicate the necessary resources — medications, research, and equipment — to all of those in need, because none are protected unless all are protected. Perhaps we can agree that the health and welfare of patients and communities should be the central focus of our united profession as a collective whole.

We absolutely must advocate for the protection and well-being of our colleagues as they place themselves in harm’s way to provide this care, and that advocacy should be reality and team based. Let us adopt a culture in our profession of distributed justice, of ensuring our focus is on relieving suffering and curing disease that is blind to economic, racial and ethnic backgrounds.

In order to receive the respect and deference we need to create necessary change, differences in specialty training must become subservient to our common calling as physicians and our need to be unified in our advocacy for health and health care. Imagine responding to the next pandemic under the leadership of health care professionals with a unified approach to prevention, treatment, care and recovery in which clinicians, not politicians give direction and encouragement, and in which knowledge and expertise don’t recognize economic or political boundaries. Perhaps in such a world the illnesses of a few impoverished souls will be treated appropriately before they become the plagues of the masses.

Respectfully submitted,

Dana S Kellis MD PhD FACP

Internal Medicine and Hospital Administration

Oldsmar, Florida

(Dr. Kellis writes from the perspective of the clinician who provides health system leadership)

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Addendum: It is important for perspective that you are aware that Dr. Kellis and I were internal medicine residents together in Arizona in the early 1980’s and also worked together in Pennsylvania for 4 years as associate directors of an internal medicine residency program. Importantly, Dr. Kellis went on from there to earn his PhD in Public Administration and is now the chief medical officer for a complex health system. It is also important to know that in my six years of working with Dr. Kellis, I can NEVER recall seeing him even mildly frustrated.

But his opinion editorial above, is a tad edgy. His lessons learned and shared with us, outline a road map whereby we may begin our journey to a United States medical system that creates the best safety and universal care possible by:

• Assuring resources for health care such as personnel, medications, equipment, etc; are made in the United States and able to be expeditiously moved to localized places of need.

• Acknowledging the requirement for a medical leadership hierarchy that 1) gathers, correlates, and controls information from all sources of available national and international data; 2) acts as the focal point for assigning treatment pathways to various academic medical centers to guide real-time research for identifying best practice options and recommendations; and 3) shares conclusions nationally and internationally.

• Reinforcing science. Science that has proven that: 1) humans (in the United States too) are contributing to ecological disaster thru global warming; 2) immunization of all is the only way to reduce risks of pandemics and 3) that spurious trials of non-validated medications and treatments touted as appropriate options for care, create hazardous scenarios with too frequent poor or tragic results.

• Reinforcing the cohesive bond of camaraderie among our health care workforce (doctors, advanced practice clinicians, nurses, aides, orderlies, unit clerks, social workers, pharmacists, therapists, mental health providers, and many others,) that celebrates the value each brings to the work of healing human beings and securing their lives through that shared effort.

• Convincing our medical profession and our government that both need to create a culture that prevents and cures disease, relieves suffering and is blind to economic, ethnic, racial and sexual considerations; and

• Lastly we need to heed Dr. Kellis’ profound words that: a few impoverished souls can produce a plague for the masses; and “no one is protected unless everyone is protected.”

Dr. Kellis has provided me with emotional and professional encouragement to continue to advocate for our less fortunate (now arguably the overwhelming majority of our) citizens whose lives are daily challenged by health issues compounded by social and economic
considerations. Perhaps with my humble efforts (and yours too) our country will do better. IT MUST!!

Stephen F. Hightower MD FACP
Geriatric and Internal Medicine
Rio Rancho, New Mexico

(Dr. Hightower edits The HealthCare Papers)
VI. Long Reads: Essays and Fictions
Medicide — A Failure to Make Whitefish Bay

By W Ryder Black

Saturday evening, the gentleman’s symptoms progressed. Unmistakably, a gallstone had again migrated into his cystic duct. With forbearance, it would dislodge. Pain, nausea and vomiting would abate.

Completing his 60th year, even with the board, he had started anew. Some success, a smidge of glory and much tragic failure were in his rearview mirror. His involuntary step-away awarded freedom of choice and space. Insightfully repentant, humbled, he would make amends.

Understanding the hazards of complexity, he structured simplicity. He pursued but one goal and one wish. These four years later, his eyes remained on the prize.

He lived comfortably in a sparsely furnished studio apartment in a declining Victorian. Turrets, fireplaces, and windows bespoke of prior grandeurs. His landlady, herself anciently elegant, had inherited the massive home and little else. Tolerant of enigma, she was pleased to have this sustaining quiet, reliable gentleman as her lone tenant.

A century before, the mansion had been built to celebrate a trophy wife. Simultaneously, the homestead and a Donald Ross championship golf course were carved from the edge of the then prosperous semi-rural city. Although time had eroded community, Victorian and club luster, glimpses of past sophistication remained.

Repetition eliminated the perils of variability. His each day repeated the former. Arising when sun and hormones nudged, coffee and stretching woke him. As spirit, soul, mind and body gelled, he wrote — a skill he had begun to master on incarcerated ‘sabbatical.’ Pursuing perfect words and phrases, he transcended time and space.

Each afternoon, he walked uniformed two miles to his fast-food post — his rationalized “daily constitutional.” His employer was elated to engage this elderly conundrum. Worn-out herding and replacing mindless teens, she revered this well-spoken, literate senior. Despite skillful proficient probes, she knew but two things about him: his age (now just shy of Medicare) and his social security number. Mystery cloaked all else.

His reliability, interpersonal communications, grammar and manners were impeccable. Although his mettle was steel, his demeanor was meek. A touch of protective eccentricity signaled rough colleagues and neighborhood toughs to stay in their lanes. Although his gestalt
suggested a meaningful past, no trappings of where or what had been were perceptible. To most, he was agreeably invisible. To frustrated curious, he was a story to be told.

The tranquility of his late-evening walks home allowed the good — plans for his next morning writings; and the bad — repressed rememberings. His had been rising and falling seas: a hard scrabble youth, a college and professional school tsunami, the Doldrums’ stall and then ascension to career success. Dedicated, talented and lucky, he cruised until tragedy struck. He planned. God laughed. Heroics required, he mustered weakness. Foundering, family, friends, career and freedom dissipated. Submerged, the sea would not take him. In tattered shreds, he washed up on this shore to start life again.

Safely home, the late-night internet (his only extravagance) immersed him in literature, cinema, music and sport. Wagering verboten, he fared well against on-line bridge, poker and book-making expertise. Streaming, he found infinite joy in human perfection: word and phrase; dialogue and scene; lyric and melody; executed plays. With a nod to his past, on moonlit nights he and a prehistoric seven-iron trespassed to play one-club golf until the emerging dawn threatened to reveal them.

Friends and family, rightfully done with him, had lost sight of his being. Truth — prior to his debacle, he had served them well — save for one. The youngest daughter — she had come as a gift later in life — had been rocked by catastrophic undoings in her formative years. Her family, friends, home and education had been torn asunder. Although he had no understanding of intervening processes, viewed from a cautious distance, she and her young family appeared happy, prosperous, well-educated and secure. His goal was to pay in arrears for the education he had not been there to provide. His method — as long as circumstances allowed, his trustworthy solicitor would anonymously gift $1,000 per month to her bank account.

Beyond clothes, seven iron and computer, his studio held but one personal effect — a print of the Edmund Fitzgerald hung above his writing desk. Prominent, it was there to remind him of the poet’s words, “The searchers all say they’d have made Whitefish Bay if they’d put fifteen more miles behind her.” It served as a metaphor for his wish — staying healthy until he, uninsured, made it to Medicare.

Living in the wealthiest country on the planet, the math was devastatingly simple. Working full time, he was not provided health insurance; if he purchased health insurance he would have no funds for his daughter; and if he purchased health insurance and became ill, deductibles would leave him destitute — a humiliation he could not abide. After simple ciphering (insurance $700/month — $8,400 per year — would only kick in after $8,000 of deductible expenses), he chose to meet his obligation to his daughter.

Having chosen his ancestors well, he was blessed with good health. Professionally trained, he adeptly navigated diet, exercise and minor ailments. Late-night warmed lemon
water replaced demon rum. Over-the-counter ibuprofen became his aged creaking joints’ best friend. Minor illnesses were bumped through.

Month after month, routine fared him well. Capturing his vast life experiences, his morning writings were generally proficient and sometimes masterful. Organized as short vignettes, he amassed several hundred in an ever-expanding desktop folder. As his anthology grew, he recognized increasing value as a source for script writers in search of ideas. His afternoon and evening labors paid bills, moderated obligation and assuaged guilt. Gracefully accepting deserved solitude, joy far surpassed evening loneliness and lament.

An hour in, the pain, nausea and vomiting uncharacteristically intensified. Soon thereafter, he comprehended agony. Without fear, he perceived that this night he would not make Whitefish Bay. Reviewing his meticulously ordered directives to his solicitor regarding his humble personal effects and treasured anthology, he found peace.

The onset of fever and bed-shaking rigors heralded doom. In most developed nations, he would be ministered safe, effective, compassionate care. In America, he faced and could not endure the shame of being impoverished by exorbitant charges — charges that, just several months hence, would be negotiated, adjudicated and largely paid for by Medicare.

His fate decided, as a feint he slipped a note beneath his landlady’s door — he would be away until late Monday. Defeated by nausea and vomiting, he was unable to keep analgesic down. Mercifully, precious, aged single-malt, cracked for “emergency medicinal purposes” (one shot as necessary every 15 minutes), clouding sensorium, alleviated nausea and pain.

Monday, when he failed to present on the dot for duty, alarm was sounded. By Tuesday, his tragic abdominal sepsis demise was sufficiently, for most, explained — overmedication with scotch impaired judgement. One, his solicitor (with an ancient golf club and a print of a sunk ship as prized remembrances of an admired, cherished friend and instructions to shop his anthology to the benefit of his daughter’s family) fathomed truth — in the wealthiest country in the world, a proud, imperfect, good man, atoned and judged even with the board, had failed by weeks and months to ascend to the privileged class — insured by Medicare.

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Medicide – A Failure to Make Whitefish Bay
W Ryder Black (aka T Michael White MD)
2018-11-27

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Hagerstown Maryland 2018
#2EF Coronavirus — Our Health Care System Exposed
David Emory Lippman MD

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Evansville, IN 2020

Coronavirus — Our Health Care System Exposed
By David Emory Lippman MD

“The basis of optimism is sheer terror.”
Oscar Wilde

Entry: Early March 2020

Maybe it’s me. Maybe it’s not so bad. But my mind paints an apocalyptic end to the current health care system in America in the near future. From my perspective, the Coronavirus simply demonstrates the total lack of public health infrastructure and primary care in our country.

Why?
Because, in America, we just accept our deaths. They are only Americans that die? I mean, really, what are they worth?
Our life expectancy is less than Costa Rica’s.

We are the only industrialized country in which life expectancy has decreased. And who realized the cause? The American Medical Association? The Centers for Disease Control? No. Two economists who realized that middle aged Americans like myself were killing themselves like mad which they described as “deaths of despair.” There is a show on Netflix called 13 Reasons Why about teenage suicide. A middle-aged version of the show is needed. In all honesty, poisons to choose from are the same — guns, alcohol, fentanyl and other opiates.

Or look at the Coronavirus. Have you seen the global tracking of Coronavirus from the Hopkins website? As I write this, on March 6, 2020, our country has the highest percentage of deaths of any other country infected. Any.

Although there are many more cases in China (from which it originated), their death rate from confirmed cases is 3.75%. Our death rate from confirmed cases is 5.93%. Let’s compare our response to other countries:

- we have 236 cases with 14 deaths, a mortality rate, as above of 5.93%.
- China has 81,573 cases with 3,042 deaths. Mortality Rate: 3.75%
- Japan, (located much closer in proximity to China where it originated) has 381 cases with 6 deaths, or 1.57% mortality rate
- Germany: 578 cases with 0 deaths. Mortality Rate: 0%
Spain: 360 cases with 5 deaths. Mortality Rate: 1.39%
France: 577 cases with 9 deaths. Mortality Rate: 1.56%
Iran: 4,474 cases with 124 deaths. Mortality Rate: 2.77%
Italy: 3,848 cases with 148 deaths. Mortality Rate: 3.85%

Why is our death rate so much higher? I believe it is because other countries actually care about their citizens. One death is too much according to them. America? “Well, we lose more people to the flu.” “Well, more people die in motor vehicle accidents.” “Well, more people die from suicide.”

Once the virus hit Japan, the ENTIRE country stopped school for 2 weeks to contain the spread. One of our epicenters is located around Seattle Washington. In King County Washington there are 51 reported cases with 12 deaths. A mortality rate, in that area of 23.5%. Now, it is true, that they did close SOME schools but many if not most are still open as I write this. Think about this as compared to Japan. Japan closed ALL schools, ALL across the country. America can’t even close all schools in one city “because, you know, it’s a hassle.”

In Japan, one death is too much. In America, well, more deaths occur from other things. And, anyways, most dying are old and elderly anyways.

And, it might affect the stock market.

Think of the irony. The Bill and Melinda Gates Foundation helped fund Event 2019 on October 18, 2019 at Johns Hopkins. This event brought thought leaders from across multiple disciplines to see how we would cope with a Coronavirus pandemic. In this tabletop exercise, they assumed such an epidemic may kill 65 million people worldwide. In reality, a REAL Coronavirus epicenter for America is taking place right now in Seattle where Bill Gates’ company, Microsoft, is based. And where Amazon is based. Two trillion dollar companies which hardly pay any taxes. They could easily take a billion dollars each and fund their own Health Department in their own county to stop a virus that can affect their OWN workers. And, yet, they haven’t.

The only hope for Americans is that, if an individual gets it, they likely have a 95% chance of living.

As stated, from my perspective, the Coronavirus simply demonstrates the total lack of public health infrastructure and primary care in our country.

**Entry: Late March 2020**

From my perspective, as of March 28th things have gotten worse than I could have imagined. When I first wrote this, there were 236 cases in America. Now, we lead the world in cases with 121, 489. Our mortality rate has decreased because we are testing more but it is still much higher than many other first world countries. For example, ours currently sits at 1.7%. while Germany’s is at 0.8% and Canada’s is at 1%, for instance.

Tragedies have overwhelmed the healthcare systems in Italy and Spain, but I think at the end of this pandemic, we will have a significantly higher mortality rate than many other first
world countries. New York City alone has 517 deaths and I believe they will surpass all the reported deaths in China. That’s just one city. Next comes New Orleans, then Los Angeles, Detroit, Chicago... Personally, my father-in-law is recuperating from COVID-19 Pneumonia in western Massachusetts and my mother-in-law is deathly sick with COVID-19 and has been on a ventilator for 12 days. She will likely die from it.

As a primary care physician working in America for nearly 20 years, this has placed the final nail in the coffin for my faith in the American medical system. It has failed its citizens and it will continue to do so. Joe Biden said it was impossible to spend 20 trillion dollars over 10 years on Medicare for All. Yet, because we are unable to treat this medical problem, we have lost over 15 trillion dollars’ worth of equity in the stock markets just this month and the government spent over 6 trillion dollars to cover the economy for 1 month. I do not believe the markets will regain their footing until we know this medical situation is resolving, but we are too poor to pay for such a system.

The health care workers on the front line fighting this pandemic are being knowingly sacrificed with little personal protective equipment and changing of CDC rules to make sure they can “get back out there” to fight the virus even if they themselves are infected with the virus.

Tick, tock America. The virus is coming for you. Tick, tock...

*****

Coronavirus — Our Health Care System Exposed
David Emory Lippman MD
2020-03-28

*****
To: The President of the United States  
The White House  
Re: 2-Club Pandemic Golf — Avoiding the Rule of Unintended Consequences

Dear POTUS Sir,

The top of another perfect Florida morning to you and yours.
Thank you for all you do daily so well for so many. As the kids say, keep on keeping on.
I am flattered that you, a founding member of The Legends in Own Mind (LIOM), remember my induction into the society. Becoming an official card-carrying Certified-Legend in Own Mind (C-LIOM) and joining esteemed likes-of-you shall always remain my life’s foremost accomplishment.

Regarding your inquiry — yes, I have expertise in 2-club golf. Since many regard me as the inventor of 2-club Golf, humbly (as humble as a C-LIOM can be) I must concur.

Getting to the point, as you intimate, it would be wrong to close (your) golf courses during a pandemic. While accommodations must be made (cart cleansing, elevated holes, rakes, sand scoops, flagsticks, hand sanitizer, etc.), the sacred pursuit of spheres about improved farmland can and must go on without fear for contagion.

The 2015 document that you request is inserted just below. It had been submitted (and rejected) for publication in Golf Erratum. It describes in pre-social distancing terms the genesis of 2-club Golf. I can ensure that in these complex times, given the verities of fades and draws
and the electronic settling of wagers, that 2-club Golf match play need never violate Center for Disease Control spacing guidelines.

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Hub City 2015

2-Club Golf
By W Ryder Black

Prologue

The early December 2015 newspaper release:

Old Coot Wins The Coot

Elderly 2-Club Golfer Shoots Age (78)

requires some explanation. It started with a harmless letter from your average, low-maintenance, not a bit eccentric, quite perfectly mannered country-club member merely requesting advice from the golf professional staff about a proposed kind and gentle letter to the golf committee.

******

Personal and Confidential

November 06, 2014
To: PGA Professional Staff
       Crystal Spring Golf Club
       Hub City
Regarding: Advice and Counsel

Dear Arnie, Jack, Gary, Lee and Dottie,

Thank you for daily making the experience of golf so wonderful for my family, my friends, my guests and me. Thank you for possessing the expertise and the courage to accomplish this.

At this time, I will again benefit from the grace of your wisdom. It appears my approach to finding joy in chasing a ball with a stick about 18 holes has once more ruffled feathers. Despite opinion to the contrary, riling is not what I do best — but, proudly, it does rank up there. Towards smoothing, please consider this letter to you and the attached draft letter to the our fine golf committee and then advise.

From the beginning, golf has spoken to me. From the beginning, lessons learned from the joys and tribulations of succeeding and failing at the game and their applications to family, career and life have been apparent to me.
The game was introduced to me from all angles. Legend has it that I took my first barefoot steps on the practice green. Soon I was giving it my competitive best at the muni — "Joey, we halved par 3 with nines so I remain one-up." Advanced equipment, formal lessons, an understanding of and perfection of the swing and a direct path from my blue collar roots to golf greatness were not to be mine. In high school, I did become a respected AA caddy — I consider it my first profession. It taught me all required to address professional and personal life: strength, courage, etiquette, fairness, fear, honesty, justice, kindness, politics, power and the sanctity of one’s word. Lessons were taught by the legends (in their own minds) I served, and by my fellow caddies — after reflection, more by the latter. Lessons learned have served me well.

After medical school, internship and residency, my first order of business in transitioning from years of abject poverty to employed practicing physician was to take up the game in earnest. My only true escape from relentless responsibilities was found beyond the 150 marker of the club’s first hole. Once off the tee, they could not get to me. Gradually, the golf swing became less mysterious. The club’s protocols, rhythms and grace became second nature. Players walked and executed. Caddies (the next generation of executives, physicians and golfers) carried and advised. Ah — golf as it was meant to be.

That door to golf heaven slammed shut when my career took me to the big city. Carts replaced caddies. To preserve club cash flow rules were made — rule #1: you had to take a cart. Four hour walks became five hour stops-and-goes. As players’ physical exertion diminished, their fitness deteriorated. Children became less welcome on the course. Caddies vanished. Golf’s links to its past and next generations eroded.

Now, the golf industry is panicked. Its participating audience is shrinking. More and more, it has become a game only for older (and older) adults who (with increasing difficulty) remember how it is supposed to be. Where have all the players gone?

To enhance involvement, the game is becoming participant friendly — what an idea! Tees have been moved forward. Dress codes are more contemporary. Caddies are still nowhere to be found but it has become permissible (if not totally socially acceptable) to walk with a cart or carry a bag.

In my dotage, I have tried pulling/pushing carts and I have tried carrying my bag. I love the exercise and its salutary impact on my physical and mental health — 9 holes over gentle hill and dale equates to about 4 miles, 560 calories and a clearer mind. However, both cart and bag annoy, discomfort and perturb. Uneven weights and stresses cause shoulder, hip and back ache. Nostalgic for a caddy, I have identified a likely community ragamuffin or two. Club decorum and liability concerns say no.

So I have invented and quietly play what I call 2-Club Golf. Although I have not proselytized my new game; and, although neither the game nor I have inconvenienced or
disrespected the club, I am told I have again caused quite a stir. Apparently another full-fledged club constitutional dustup is underway.

At our fine club no good deed goes unpunished. I anticipate that I am again to be called before the golf committee. The usually reliable grapevine cautions, “the powers that be are concerned that the eccentricities of your irregular forays on the course are a threat to the game that they are duty bound to protect and uphold.”

At this time, Arnie, Jack, Gary, Lee and Dottie, I look to you for guidance. Instead of a meeting with the committee (which I confidently assure will not go well), might not the attached polite carefully wordsmithed letter to our fine golf committee suffice?

Relying on the grace and wisdom our grand game has provided to and instilled in you, I look forward to your advice and counsel.

Sincerely,
Dr. W Ryder Black
Member, Crystal Springs Golf Club

Draft Letter to Golf Committee

November 06, 2014

To: Golf Committee
   Crystal Spring Golf Club
   Hub City

Regarding: 2-Club Golf

Venerated Madams and Sirs,

Thank you for all you do daily so well for so many. Congratulations on preserving and advancing the fine golf club that serves us so well. Accolades.

This starts with concern. My hearing is not what it used to be. I generally find this to be a blessing. However, now as I enter the Grill Room, I consistently perceive reference to an “old coot that plays with two clubs.” Since I am no longer young and since I regularly circle the course with less than 14 clubs, I conclude the phrase and my arrival in the Grill Room may represent more than mere coincidence.

This once, I have decided to go against where instincts naturally lead — homicide. Instead, full of holiday spirit, I wish to share the wonders of what I call 2-Club Golf so that you, the Golf Committee, may distribute them to the club proper. My vehicle — answers to frequently asked questions:

*****

2-Club Golf

Frequently Asked (polite) Questions
Q: What are the rules and etiquette of 2-Club Golf?
A: Strict USGA rules of golf apply. Traditional etiquette is respected.

Q: Are there any accommodations to the rules?
A1: A player is permitted a maximum of two clubs.
A2: To enhance enjoyment and the pace of play, a two-putt rule has been instituted (once the player’s ball is on the green proper the player is allowed a maximum of two putts). 
*Note: this significantly enhances the value of one-putts.*

Q: What two clubs are utilized?
A: Any two clubs may be utilized. Choice of clubs is a major tactical consideration. Choice will strategically vary from player to player, from course to course, from chosen tees and with conditions.

Q: What other equipment is permitted?
A: The same as in any game of golf (balls, clubs, tees, markers, gloves, shoes, etc.)

Q: What are your choices of clubs at the Donald Ross’ Crystal Spring Golf Club course?
A: I have extensive experience on the front nine. Proudly playing from the gentlemen’s forward tees, I have found the 5-wood and pitching wedge combo to be efficacious. Generally, putts are addressed with 5-wood.

Q: What are the advantages of 2-Club Golf over the traditional game?
A: From my humble perspective:
- I can walk the course.
- Walking with a club in each hand provides for neuromuscular balance.
- The encumbrance of the carry bag/pull-cart is eliminated.
- I have a new appreciation of course topography. For example, 6-tee and 6-green are at the same elevation but are separated by an abyss requiring descending and then ascending steep inclines. Who knew?
- Over nine holes, I walk four miles (560 calories). *Note: although I play from the forward tees, for exercise I walk back to the tips on every hole and then make my way forward to compete from the gentlemen’s tee.*
- I can play in 90 minutes.
- I am as likely as not to play in inclement weather.
- In proportion to rounds played:
  - My couch time has decreased;
  - My exposure to refrigerator light rays has diminished;
My muscle tone is up; and
My weight, HgbA1C and cholesterol are down.
• My mental acuity has sharpened — golf, in fact, is chess on grass.
• A gym membership is moot.
• The club has experienced an increase in rounds played, visits to the clubhouse
  and Grill Room IPA draughts served, and most importantly,
• My spirits have soared.

*****

2-Club Golf

_Frequently Asked (less genteel) Questions_

Q: Are the joys of handicapped wagering maintained.
A: Absolutely. _Note1: in the beginning, the more experienced 2-Club Golfer will prove to have an advantage. Note2: I am immediately available for a $5 Nassau. Please call 555-555-5555._

Q: Does 2-Club Golf interfere with your traditional game?
A: Quite to the contrary. As the cognoscenti will appreciate (and yes, none will care), I have four golf swings: the ferociously violent driver; the silky smooth rhythmic fairway woods, hybrids and full wedges; imaginatively creative chips; and cruel to my adversaries merciless putts. 2-club Golf requires all four swings.

Q: Aren’t you often forced to use the wrong club?
A: Yes. _Note: the beauty of 2 Club Golf has forced me have a golf imagination — the Phil Mickelson thing. I now have a feel for and can do creative things with my clubs I previously never thought possible._

Q: What is it like to putt with a 5-wood?
A: At first, it is like Henry Aaron teeing off with a Louisville Slugger on a Pinnacle Gold pitched by Nolan Ryan (picture something a smidge more nuclear). It does take some getting used to.

Q: What equipment do you recommend?
A: I find 2-clubs, glove, shoes, 2 balls, 2 tees, a ball mark and a (frequently used) ballmark repair tool suffice. _Note: for the player with less familiarity with fairway center, a full sleeve of balls may prove prudent._

Q: Is the game best played alone?
A: This depends on personal preference. Personally, unless $6 to $10 is at risk, I find that a solitary game, devoid of half-heard and incompletely understood jibber jabber, enhances concentration, alacrity, perfidy and scoring.

Q: Do hole-in-ones count when playing alone?
A: In my limited experience (in the last few months, I have only had several), I have proudly added them to my list of informal hole-in-ones. *Note: with an incomplete understanding of the fiscal protections of our fine club’s indecipherable hole-in-one insurance policy, I judiciously avoid celebration in the presence of club manager or sommelier.*

Q: What is your typical score for 9 holes?
A: Assisted by the 2-putt rule, when playing alone I average 1 birdie, 4 pars and 4 bogies (39). In formal competition — “If I could just once play my usual game” — I average 43. *Note: to understand the (39/43) discrepancy please give the above — Q&A: is the game best played alone? — a careful read. Attention to the derivations and meaning of the word perfidy may enlighten.*

Q: Do you play in the freezing cold?
A: When the wind chill is below 44, I revert to 1-club, zero-ball golf (a treatise for another day). My preferred defensive club (fox, deer, Canadian geese and squirrels — mostly squirrels) is 4-hybrid.

Q: If a 2-Club Golfer approaches a slower moving foursome of ladies playing an important, serious match, is it permissible to request a play through?
A: This question tests psychiatric and cognitive capacity/competency and not golf etiquette. Recognizing it as the trick question it is, it will not be dignified with an answer. *Note: if considering a follow-up question re: playing with spouse — don’t even go there.*

Q: Can a player ride a cart and play 2-Club Golf?
A: Surely.

Q: If a 2-Club Golfer rides a cart should the 9-hole cart fee be less (for example 2/14 X $18 = $2.57)?
A: Caution. You are now officially over-thinking this. *Note: in the interest of club solvency, I advocate full cart fee and am not adverse to a walker fee.*
Q: Returning to the beginning — what is the definition of coot?
A: In common parlance “coot” usually predicated by the modifier old, is a derogatory term describing an eccentric or crotchety person, especially an old man. Senility is generally implied. Further investigation reveals its origin in the archaic Gaelic — *coet daeg auncien rice* — a phrase murmured in the gloaming in response to protestations of elder slow play. In context, *coet daeg auncien rice* is literally translated — “Wise and rich, I wish you and your devil an enjoyable finish in the dark.”

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Esteemed Golf Committee, I thank you for considering 2-Club Golf. At this time I advocate, that our ascendant, forward-looking club become the local, regional and national proponent for and leader in 2-Club Golf. To this end, I eponymously pledge $1,500 towards a permanent trophy to be presented to the winner of an annual late autumn Crystal Spring Golf Club 2-Club Golf Championship — *The Coot*.

I very much look forward to hearing from you.

Respectfully submitted,
Dr. W Ryder Black

*Personal and Confidential*

Epilogue

It turns out that personal and confidential is not all that it used to be. The club’s always well-oiled yet chronically disgruntled bartender took charge of opening certified mail the day the above letter and attached draft letter arrived for professional staff review. After several careful read-throughs, he deemed contents excitingly cheeky and too precious for addressee review and delay. Posthaste the letter and draft were before bulging (club manager, club president and golf chair) eyeballs. Although intended recipients were never included in distribution, regulars at the bar seemed well-informed. Mob consensus was immediate — such practiced, protracted, impertinent insolence would no longer be tolerated.

After several emergency, closed-door, special, executive-session golf committee and board meetings with lawyers present, it was decided:

1. Unanimously favored termination of club membership would not pass dug-in, protracted, expensive legal scrutiny.
2. Crafting and delivery of a blistering letter of reprimand would likely lead to unintended consequences (such as delighted publication in the local newspaper).
3. Passing a ruling requiring 14 clubs would violate USGA rules.
4. Cursed instigator aside, 2-Club Golf may benefit golfers (enjoyment, exertion) and club (rounds played, revenues, membership, and publicity).
5. A voluntary late autumn tournament would be all advantage and no harm.
6. Rationalizing, his $1500 trophy donation could be viewed as a self-imposed fine; and
7. Oh what the hell, the Old Coot has got us again.

After one season of 2-Club Golf, the club leadership was polled and begrudgingly admitted success. Enthusiasts were enjoying the game for all the reasons mentioned. To maintain revenues, the club imposed a walker fee to no complaint. Participation in formal tournaments has escalated. Memberships, lessons, golf shop traffic and food and beverage sales are up. Traditional golfers and 2-Club golfers often go head to head. 2-Club golfers hold their own.

The field was full for the 2015 *The Coot*. As mentioned, the Old Coot himself was victorious. The 2016 tournament will be expanded to two days. It is anticipated that Golf Channel cameras will be on the premises.

W Ryder Black
2015-11-06
Hub City

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Hub City 2015

Thursday, March 26, 2020 continued...

*POTUS Sir, although vigilant for other unintended consequences of pandemic social distancing (for example, forbidding healthful solitary walks on the beach or solo swims in chlorinated pools), these will remain topics for another day.*

*Regarding the attached document, thank you for resolving the issue of the priggish golf committee mentioned by buying-out the club and disbanding the membership. The renaming of the historic club to *The POTUS* was a nice touch. Changing its 2-club tourney from *The Coot* to *The Chief* was genius. Who knew *POTUS, Chief* and 2-Club Golf were trademarkable.*

*Speaking, of course not for myself but for disgruntled members, while appreciating your POTUS/C-LIOM important busyness, receipt of buyout checks (plus several years of accumulated interest) will go a long way towards restoring and then advancing trust in your administration.*
Looking forward to a round of 2-club Golf with you at my former club this is submitted...

Respectfully with fondest personal regards,

W Ryder Black (PPPWG/C-LIOM)

(pretend patriarch, physician, writer, golfer/certified-legend in own mind)

*****

2-Club Pandemic Golf — Avoiding the Rule of Unintended Consequences

W Ryder Black (aka T Michael White MD)

2020-03-26

*****
#4EF  Pandemic Golf

Anonymous

Sunday, April 5, 2020
Editors The HealthCare Papers,

After publishing 2-Club Pandemic Golf (see #3EF above), that which follows appeared without attribution in my email inbox. It was clearly written by a physician, (talented) writer, golfer. For me, its unique locution, lexicon, syntax and rhythm were telltale. Confronted, the logical perpetrator (who remains guilty until proven innocent) and notoriously bad dissembler abjectly denied. Too well written for me to take credit, what am I left to do?

A careful read demonstrates this is about much more than golf. For me, dedication to compassionate care of fellow souls leaps from each paragraph. Sensing there may be important messages for others, it has been submitted for publication as relevance towards and reference for both the invention of an American health system and the grand game are clear.

Respectfully submitted,
W Ryder Black

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Pandemic Golf

By Anonymous

“Don’t play too much golf. Two rounds a day are plenty.”

Harry Vardon

“You are meant to play the ball as it lies,
a fact that may help to touch on your own objective approach to life.”

Grantland Rice

March Madness is cancelled, the NBA is shut down, the Masters is postponed, and my Aunt Marge’s senior bowling has even thrown in the towel. Now restaurants and bars are closed, and our 40-handicap governor is threatening to shut down all entertainment facilities including golf courses. I have not tested positive, but the coronavirus is killing me.

There is nowhere to go and nothing to do. My wife suggested we take a walk, but I don’t walk anywhere unless I have a golf club in my hand and it’s cart path only. Our kids have a restraining order on us and won’t let us come within 200 yards of the grandchildren. And we can no longer eat out, but when we tried to cook at home, there were cobwebs in the oven.
The network channels are inundated with coverage of the virus. The golf channel has been showing reruns of old tournaments, which are almost as riveting as watching my brother-in-law's video of his family camping trip to Yellowstone. And my wife is so desperate for something to do, she is even considering sex, and maybe even with me.

Paranoia is off the tracks. Before the shutdown, we were having dinner at a local bar. I let out a loud sneeze and everyone at the surrounding tables started yelling "check please." My stock portfolio is plummeting and most of our cash is currently invested in toilet paper. I am washing my hands 137 times a day. I don’t touch anyone. I don’t even touch myself. I have been using tongs to go to the bathroom. This has to stop.

Our society and economy have been crippled by a microscopic virus. Scientists have not yet determined the exact origin but have narrowed it down to a Chinese fish market or Rosie O’Donnell’s bathtub. And no one is sure how to prevent or cure it. In the past, the ways to prevent contracting a contagious disease were simple: don’t eat in restaurants with cat on the menu and don’t date a college roommate’s sister.

I don’t consider myself to be in the high risk category. I have been building up my immune system by eating one meal per day at MacDonald’s for the last 25 years. Germs just slide through me. My only pre-existing condition is an inability to launch a golf ball further than 180 yards. And, according to the CDC, symptoms of the coronavirus are sweats, dizziness, and trouble breathing, which I experience whenever standing over a 3 foot putt. I can handle it.

So, I proposed to my regular foursome the idea of escaping from our self-imposed Stalags 13 and venturing outside for a round of golf. Everyone recognized the danger and severity of the situation. But when faced with the decision to remain sequestered with our wives or to risk contracting a deadly virus, it was a no-brainer. Every man opted to play golf.

Our foursome does not pose a medical risk to mankind. My friend, George is virus free. Social distancing has not been a problem for him. Other than us, he doesn’t have any friends. Bob, my neighbor is a urologist who has been working from home for several weeks. He has developed a way to do remote prostate exams by having patients sit on their cell phone. And our other partner, Jerry tested himself with a kit he bought online. Results are mixed — no traces of the virus but pregnant with twins.

The federal government has established guidelines for social engagement. For example, you must stay at least 6 feet apart and no more than 10 people are allowed at a gathering, which means Patrick Reed’s fan club can still meet. In addition, our foursome drafted our own specific set of rules for Pandemic Golf.

Rules of Play

- Hazmat suits are permitted. As an alternative, one can wear a college mascot costume or big bunny pajamas.
• Masks are not permitted, because we would look more like stagecoach robbers than a foursome.
• Leave the flag in. And to avoid retrieving balls from the hole, any putt shorter than Lebron James is good.
• Ride in separate golf carts and don’t come closer to another player than a fully extended ball retriever.
• Don’t touch another player’s balls. This is always good advice.
• No high fives. Fortunately, we seldom have a reason.
• No petting the geese or the cart girl.
• Don’t use the spot-a-pot — more disease in there than in all of Wuhan China.
• No excuses. Slicing or hooking are not side effects of the coronavirus.
• Make an online bank transfer to pay off your bets for the day.
• Straddle the sprinkler on the 18th hole before getting into car.

These rules and restrictions adequately protect us from contamination. Unfortunately, there is no vaccine for bad golf. I had trouble gripping the club with oven mittens, but it was an enjoyable afternoon which ended way too soon. There were no handshakes on the 18th green, no beers at the bar, and we drove home separately.

As the pandemic plays through, it is giving us a glimpse into our inevitable future where all meals are delivered, all entertainment comes through the tv screen and all human interaction is through our cell phone; where schooling is online at home, exercise is on a stationary bike in our basement, medical testing is done at drive thru windows and colonoscopies are performed at Jiffy Lube. The world is changing. It is becoming less interpersonal as technology consumes us.

So, now that we have time on our hands, everyone should take a moment to cherish this fading era, when friends still get together to hit a little ball around an open field for no good reason other than to enjoy the companionship of their fellow man.

Pandemic Golf
Anonymous
2020-04-01

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VII. Epilogue *(a work in progress)*

Time will decide the relevance of this attempt at important, meaningful work that will make a difference. Success will be gaged by salutary impact. If worthy, please support this effort by both contributing your thoughts and by bringing this work to the attention of editors and publishers in your sphere of influence.

*Respectfully submitted,*

*Stephen F Hightower MD FACP*

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*T Michael White MD FACP*

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*Belleair, Florida 2020*

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