The lessons of an Oslerian cardiologist

"Be careful when you get into practice to cultivate equally well your hearts and your heads."

-William Osler

A defining moment in my young career occurred during my first job at a private practice. There were just a few primary care doctors in the practice, and we took almost total care of a small rural town. The practice boss was a good guy and a caring doctor, but he was also a businessman, and he sought to increase revenue without us having to see twenty patients a day. "Bad for us, and bad for them," he said of the patient rat race that was needed to keep us financially solvent.

So, he bought an ultrasound machine for the practice; it's always more lucrative to do procedures and tests in the American medical system than to see patients. To that end, we also owned our own lab. In fact, almost half our income flowed from sources outside of what we were paid to spend time with our patients. Insurance in a Flexnerian system does not adequately reimburse thinking or discussing or examining or doing anything directly with our patients. Its focus always is to test, diagnose, and fix, with most of the money flowing toward the machines and drugs (and the doctors who are fortunate enough to own and use those machines) that are needed to test and fix. And for that, you need stuff like ultrasound machines and a lab if you want to cash in. It's far easier and faster to read an x-ray than to decipher the issues of a complex patient with multiple medical and psycho-social problems during a face to face visit, but the x-ray interpretation pays a doctor a hell of a lot more in much less time!

I was a young doctor seeing a lot of patients every day; that's what I loved to do, and I felt that I was able to help them to negotiate their health problems and their many medical worries. One day the practice boss called me in to talk about my performance, and this is the defining moment to which I referred.

"You're doing a great job, people love you, your practice is growing, and I have nothing bad to say. But," he then uttered, smiling at me. "there is a better way to do things. If you end your visits ten minutes sooner and order a full panel of labs, even an ultrasound (most people need an ultrasound of something!), then we will make more money, your patients will be happy because they will think you are being thorough, you can bring them back for a quick visit to discuss the test results, and you will have time to add more patients to your schedule. It's a win-win-win for everyone! You should think about it!"

I may have thought about it for a few minutes, but really, it just didn't feel right. And I wasn't the only one not buying into this new approach to care.

Very few of the doctors were making use of our new ultrasound machine as well.

One day our practice boss passed out some carefully selected articles demonstrating the efficacy of checking people's carotid arteries with the new ultrasound machine. "We can find blockages early and then fix them before they get a stroke." He advocated doing carotid ultrasounds on everyone! "It's a win-win-win," he said again. "The patients will appreciate our thorough care, and it's good for us too."

The data he presented was real but specious. Like with most medical literature, you can find studies to support virtually any intervention you seek to endorse while you can quietly turn your back on any studies that get in your way. Only much later did I read those studies more critically, and most showed

no survival benefit with ultrasounds, all were done on young people with symptoms, and many people actually developed strokes from the surgical procedure that was done to fix what were likely harmless blockages that the ultrasound unearthed. Finding blockages and fixing them (which was Flexnerian gospel) led to more strokes than it prevented; it was more harmful in many cases to get the test than to not be so "thorough." No one could argue that it was more profitable to do the test!

One day I received a call from our town's cardiologist. He was young and funny, passionate as hell, and he was pretty much the only heart doctor to which we dared refer our mostly working class patients. Our doctor-boss hand-picked the guy to come to our town, and he did have a heart of gold without an ounce of greed.

"Are you aware that Dr. M [our boss] is ordering carotid ultrasounds on people who are really old and really frail?" he asked me. "He wants me to give surgical clearance to a healthy 90 year old guy who is doing just fine but who now is discovered to have an 80% blockage in one of his carotids. Are you ok with that?"

To this day I am not sure why he called me and not the doctor-boss, who after all was the one who ordered the test and authorized the surgery; maybe even then my skepticism about our aggressive medical system had trickled out. He continued: "We shouldn't be doing these tests on people without symptoms, especially people so old. If we look too hard at these guys we will find stuff that we should really just be leaving alone. I'm not sure how to handle this, but I don't want this guy to go for surgery, and I don't want to start doing more tests on him just to prove why."

I didn't know what to say. But the experience did open my eyes.

Only twice in my career has a cardiologist tried to talk me out of doing a test or procedure. Virtually every other time the cardiologists with whom I have worked push hard to put my patients on medicines, order copious and frequent tests, and undergo "necessary and life-saving" procedures. They rarely pause in their zealous insistence that everything has to be measured and fixed; the more arteries we open, the more we lower LDL cholesterol, the more people are on blood thinners, the lower we push down the blood pressure, the better everything is. But this cardiologist, he was different. He thought about every test through the eyes of his patients, he did not believe in measuring or fixing numbers or opening blocked arteries, he instructed us about why not to do certain tests and not to order certain drugs. He was not rich, he was not poor either. He didn't seem to care. What he was was an advocate for his patients and a well-read, thoughtful, and critically thinking physician. He was a true Oslerian.

Many years later I would encounter another Oslerian cardiologist, and I had the privilege of working with him for over a decade. I still consider him one of the smartest and most devoted physicians with whom I collaborated, and to this day he is a good friend. His name is Dr. C.

After my friend Erik had his heart attack that I described in an earlier chapter, after he was told by a squadron of doctors that he must swallow a plethora of "necessary and life-saving" medicines including blood thinners and high-dose statins and drugs that plummeted his blood pressure, after he could barely walk or function and feared for his life and his future, I sent him to see Dr. C. My friend remembers the visit well.

“He told me that all those doctors would try to scare me, but in fact I was just fine, I didn’t need all those medicines, I didn’t have to go for more tests and visits like they insisted, and I could live my life and not worry. Once he said that, a huge weight lifted off my shoulders, and I felt like myself again.”

That was Dr. C. He knew his patients, he knew the actual risks and benefits of interventions, he understood the danger of excessive testing, and he was able to customize care to each of his patients in a way that was consistent with their conditions and their wishes. His notes were masterpieces; he explained every decision he made, talked about his discussions with patients, and often cited scientific studies. The truth is that he was often running behind in his schedule, because he gave all of his patients every bit of time and thought that they needed.

Everyone with whom I worked, including my office staff, recognized how special Dr. C was. My medical assistant, who has worked with me for almost twenty years, constantly sang his praises, and does so to this day; she is not one to hand out compliments very readily. But she knew how much he cared about our patients, and the fact that he treated them—and her—as an equal; he never looked down on anyone, and always had time and eagerness for explanations and discussions. Passion and knowledge flowed through his veins.

One day I received a call from Dr. C about one of my patients, Mrs. L, who I had sent to him for an ultrasound of her heart.

“Why do you want this test?” he asked.

“Well, she has a narrow mitral valve,” I said. “And I figured it would make sense to keep an eye on it and just make sure it’s not progressing. She hasn’t had an ultrasound for a few years.”

“What would you do if it’s worse?” he asked. “I’m just wondering.”

I paused for a moment. So much of what we do is knee-jerk that we don’t fully contemplate the ramifications of our decisions. We are so imbued with Flexnerian thinking that it’s natural to assume that if someone has a narrow heart valve then it’s right and proper to measure that valve periodically and then fix it if it gets too narrow. Test-diagnose-fix. It’s a ringing mantra in our heads.

Without a doubt, it was more in Dr. C’s financial interest to endorse the heart ultrasound rather than to eschew it; his practice owned the ultrasound machine and he would be paid a hefty fee both for doing the test (facility fee) and for interpreting it. In fact, one heart ultrasound may take up 20 minutes of his time, but would pay him as much as it took me to see five patients! And too, the time he now took to call me and discuss this with me bit into his bottom line. No wonder he was the lowest grossing doctor in his practice, something that would soon come to haunt him.

By the logic of Flexner and of my first doctor-boss, getting the ultrasound was a win-win-win; even Ms. L would be happy with the thorough care that we were giving her by keeping an eye on her valve.

I didn’t quite know how to answer his question. “I guess it’s just good to know that the valve is doing ok,” I finally uttered. “I’m really not sure what I would do with the results.”

“I know Ms. L pretty well,” he said. “And she really doesn’t have any symptoms that would warrant looking at her valve. Even if it’s more narrow, she has clearly compensated, she is walking a few miles a day and feels well, and the last thing she needs is for us to start coming at her with knives and pills to fix

a problem that's not bothering her. Besides, I've talked to her about surgery, and she told me that even if her valve was critically narrow she would never want to have it fixed. So, I just don't know what we'll find on this test that's going to change anything we do, other than maybe make Ms. L a bit more nervous than she has to be."

Wow! It was another eye-opening moment for me, and not the only one I had at the bequest of Dr. C. Just his notes were often a learning process! I often wondered—and still do—how our medical landscape would be different if all consultants were like Dr. C; in other words, if they were actually consultants in the way that both Osler and Flexner envisioned, who utilized their expertise to help us make good decisions about patient care, rather than being a bunch of businessmen who justified their win-win-win approach by hiding behind a white coat and a thin veil of self-selected science.

Because he was so well respected, because he did order and perform enough tests and interventions to earn his keep (given the bloated reimbursement rate for ultrasounds, stress tests, and catheterizations, it didn't take too many for him to bring in a lot of revenue), because he was one of the practice's founding members, Dr. C remained a fixture in his practice, and he was always my go-to guy.

Then, in an instant, everything changed.

Health economics exists in a shifting atmosphere, and what makes sense one day is not prudent the next. At that time, many practices like Dr. C's were in a position to earn more money if the hospital owned them. They could still manage most of their own affairs and still recoup most of their money from procedures, but now the hospital would facilitate their processes and ultimately control and maximize their revenue stream.. And that is just what Dr. C's practice did.

Even though Dr. C earned a decent amount of money, now it was not enough. The hospital purchased his practice because it was a cash cow; cardiology procedures generate such huge revenue flows that they alone can augment a hospital's income and compensate for some areas of loss. The hospital bought the practice so they could reap in the river of cash. And compared to his colleagues, Dr. C wasn't playing the role that was now assigned to him.

I spoke with him often during those next few years. He felt the need to vent. He did not know what to do. Hospital administrators met with him regularly, showed him his numbers, berated him for his lower than expected revenues and his miniscule rate of ordering tests, threatened him with salary reduction, even compelled his partners to encourage him to be more of a team player. Not once did they mention or care about his passion, his concern for his patients, the large amounts of time he spent with them, the fact that everything he did was based on scientific data and individualized patient choices. Even while the hospital declared its profound advocacy for shared decision making between doctor and patient, and the value of patient-centered care , they derided Dr. C for doing just that. Patient-centered care was well and good, but how could doing fewer tests possibly be in the patient's best interest? It is amazing the capacity of human beings to justify and convince themselves of the value of a win-win-win approach! Flexnerian thinking makes such a leap possible!

Dr. C was not about to be sucked down a hole that he believed to be contrary to his core beliefs and to the role he coveted as his patients' doctor. He also had no interest in leaving his practice and losing his patients. So, he agreed to a pay cut. And for a while, the hospital complied.

But soon enough, that wasn't enough. Not only the hospital administrators, but soon his friends and colleagues from within his practice, demanded that he change his ways. They met with him even more frequently, they went over specific patients with him and tried to demonstrate why he was wrong in not doing more tests, and finally they gave him an ultimatum: leave the practice or do what you are told.

"You know what I think?" I told him as he relayed the story to me. "Just having you in this practice is a threat to them. The fact you can cost Medicare so little money and still have good outcomes, that's the last thing the hospital or your practice wants to see, especially given that so many patients join your practice just to see you."

He wasn't sure, but he decided to fight back. "Pay me as little as you need to," he told them. "I just want to earn what I make minus my overhead. I don't mind."

That didn't sit well, and so all of his friends in the hospital and his practice cut him off and pushed him out; he was a tremendous threat. That's when things got very ugly.

Dr. C decided to start his own practice. He was never sure which of his patients would remain with him and which would stay with his former practice. Sometimes he would look up his patients on the hospital computer when they were admitted just to see, sometimes he could contact his patients to figure out which direction they were going. He still did a lot of hospital work, and was a constant presence on the hospital wards.

That too proved to be unacceptable.

The next thing he knew, Dr. C received a letter accusing him of HIPAA violations for using the hospital computer to look at the charts of patients who were not his. HIPAA is a very complex privacy law that has undergone many revisions and which sets the boundaries regarding what doctors can and can't do to assure that their patients' data remains private and secure. The hospital initiated the charges and prosecuted them vigorously; they wanted him out of the hospital by revoking his privileges. None of his colleagues was willing to help him. No doctor in the hospital came to his defense.

He hired a lawyer and fought the charges. The battle cost him over $50,000 of lawyer fees plus countless hours of time and stress, lost patient revenue, and a lack of focus on his new practice. The process went on for many months, maybe longer; I met with him many times during it, and he was a nervous wreck. "I can't wait until this finally ends," he told me. "Then I can just be a doctor again."

What he and I both did not know is that it was never going to end. In fact, it was only going to get progressively more harrowing and horrible. It still is today, a decade later.

In the end he and the hospital compromised; he would relinquish his staff privileges voluntarily and no reprimands or charges would appear on his record. He was required too to take an extensive week-long HIPAA course somewhere across the country.

"I scored the highest in the class," he told me. "They even asked me to teach it when I was done. And as far as my own situation, I researched it and talked to them about it, and it clearly was not a violation of HIPAA."

Because he no longer had hospital privileges, Dr. C had to partner with another cardiology group to take care of his patients when they were hospitalized. That worked well for a while. But that group shared

coverage with other cardiology groups, and one day the coverage fell to his former group. When one of Dr. C's patients needed to be hospitalized, his former partner refused to take care of her. Since he was the only cardiologist covering that night, Mr. C's patient was left in a bind, something not resolved until the other covering group returned from vacation a few days later.

Dr. C complained. "I wrote a letter to the hospital telling them that what happened was totally unethical," he told me over dinner. "And when they didn't respond, I wrote a letter to the State health commissioner, telling them to investigate what had happened. And that's when the shit hit the fan!"

Of course, I am privy only to Dr. C's side of the story, but given the number of years I have known him, and his tendency for self-criticism and for broad thinking, I was inclined to believe him.

The health commissioner, Dr. C told me (and which I verified) was very close not only to Dr. C's former group, but also to the particular cardiologist against which Dr. C had brought the charges. The State quickly dismissed the charges, and then turned the tables, accusing Dr. C of HIPAA violations and threatening to take away his license to practice. They sent a letter to his credentialing organization—the American Board of Cardiology—asking them to do the same. All of the sudden, Dr. C was on probation, his license and Board certification hanging in a precarious limbo, and the group who agreed to help him with hospital admissions dumped him due to his bad name.

Despite this, he fought on. He hired another lawyer, paid almost $100,000 more in fees, pleaded with the state and the Board, and underwent an incessant stream of accusation and grilling. Neither the state nor the Board—much like the hospital—made its decisions in a court of laws or by a panel of peers. They could deny a doctor his credentials by whatever means they chose. Certainly they had a process to which they must adhere, but it did not involve allowing a doctor to defend himself or having others help clear a doctor's name. Their decisions were arbitrary and final.

Dr. C did bring up a whistleblower complaint against his practice, which he won, regarding unscrupulous billing practices. The practice paid a measly fee for their misdeeds, something I read about in a blurb in the paper. Dr. C also hired a lawyer to make a plea to the Board, but the Board sat on its decision for several years, leaving Dr. C in a precious limbo.

Dr. C joined two other practices in the interim. In both cases, he did not last long with them. In one job he was the hospital physician, and he was directly chided for not ordering enough tests and procedures in the hospital that the office cardiologists had wanted. "I talked to the patients in every case," he told me, "and after discussing the tests, they decided they didn't want them." Ultimately (likely for not generating enough income) he was asked to leave the practice. The next practice seemed to be going well for a while, but his probation weighed heavily on his colleagues, especially since his Board certification was not secure, and finally he was asked to leave that practice too.

Now, Dr. C is just waiting. He is no longer practicing cardiology. No longer helping his patients and other doctors like me learn from his wisdom, compassion, and knowledge. No longer using his skills and love to improve the lives of so many people.

In every respect, Dr. C is an Oslerian doctor, something quite rare in the field of cardiology or in any field of medicine.

"Osler?" he said to me when I told him that. "Who's he?"

It didn't matter. Dr. C took the road that the medical world abandoned in 1911. It was the only road that made sense to him given his own core values and his self-imposed mission as a healer and a doctor. It was for this that the Flexnerian medical community destroyed him. In fact, the forces lined up against him were so powerful that there was literally nothing he could do to fend off the onslaught.

That is my cautionary tale of an Oslerian cardiologist. I tell it to demonstrate just how entrenched the Flexnerian thinking process is in our medical society, and how much of healthcare finance is tied to its perpetuation. Not only was Dr. C a wise physician who cared well for his patients, but he also practiced in a way that would help us escape from our health care mess. He was and is the model physician in any system of the future that values patient-centered care and which improves the quality of care at a much lower cost. We needed Dr. C, and we still do.