Chapter 1
The American Medical System: Something Has Gone Terribly Wrong

In Chapter 5, I'll share with you what I believe to be the Five Key Elements of Long-Term Health. If you're glancing through this book for a "quick and dirty" understanding of my message, you're welcome to skip to Chapter 5. But I invite you to read the four preceding chapters so you'll have an idea of the philosophic underpinnings of my the message.

There are few topics more widely discussed or of greater concern in the United States than the cost and quality of medical care. These topics are central in the conversations of corporate executives and of third-shift workers. They are central in political discourse and in dinner conversations.

There is good reason for this. The costs of medical care in the United States are the leading cause of personal and family bankruptcy. Some 40 million Americans have no medical insurance. Many of them have chosen not to pay for medical insurance, but a great number are those that either cannot afford it or are disqualified because of a prior medical condition. Social conflict over the topics of abortion and physician-assisted suicide threaten to tear American society apart.

Yet even as the great majority of Americans are concerned and even terrified at the prospect of losing medical insurance and as millions of people can neither afford nor get medical insurance because of pre-existing conditions, the majority of Americans continue to believe that the United States has the finest health care system in the world. Part of this belief relates to the idea that America must be the very best in everything. Part of it, though, relates to some deeply held and yet erroneous beliefs about the health care system and how it operates. We will explore these beliefs and attendant attitudes in later chapters.

The topic of health care reform dominates much of the political debate between candidates for the presidency, for the senate, and for congress. Also driving the ruinously escalating cost***s*** of medicine are two factors: first, the cost of Medicare and Medicaid for the treatment of a rapidly growing population of older Americans with chronic medical conditions and, second, the cost of caring for younger Americans who a couple of generations ago would have died in infancy but who now live with medical needs requiring constant attention. Consider the infant born with Down syndrome. In the middle of the 20th century, he or she had a life expectancy of less than four years. Death via respiratory infection claimed the lives of these infants early and often. Now with the advent of antibiotics, the life expectancy of a person with Down syndrome approaches fifty.

A Medical "Miracle"?

Before I went to nursing school, I had to take a lot of science courses that I had managed to avoid during college. It took two full semesters and summer school to finish 42 credits of sciences. Physics, Introduction to Chemistry, Bio-organic Chemistry, Microbiology, Anatomy, Physiology, and Genetics were just some of the required courses that would allow me to gain entrance to the College of Nursing. Facing all of that and hoping to earn some income while I pursued my nursing studies, I took a six-week course that certified me as a nursing assistant.

My first assignment was for a child, Billy (not his real name). Billy was seven years old and lived with foster parents. His mother had apparently been a heavy user of cocaine while she was pregnant, and it was Billy who suffered the consequences. He had, in essence, no brain in

his skull. He had the lower brain, sometimes called the reptilian brain, whose function is to control heartbeat and respiration. Billy was blind and deaf. He could not speak. He was incapable of voluntarily moving his arms or his legs. He could not swallow and so had a feeding tube implanted through the wall of his abdomen and into his stomach. Billy's nervous system was incapable of controlling his temperature, so whenever he began to become too warm, clothes would be removed. When he became chilled, clothing was added.

During the brief period when I worked with Billy, I would arrive at his home at 6:30 a.m. His foster mother would have given him his morning tube feeding and have dressed him. Billy would be lying on the living room carpet, very still and quiet. About seven o'clock a specially equipped van would arrive, and Billy and I would board the van, Billy in a wheelchair. My job was to escort him to a special school for severely handicapped children. Being blind and deaf and incapable of speech or movement, Billy was not able to participate in any of the educational offerings of the school. Rather, he was, in essence, warehoused throughout the day.

At 3:30 p.m., I would arrive at his home and meet the bus to drive to school. Once again Billy would be loaded onto the bus in his wheelchair and be returned to his home. Once home, my job was to feed him via the feeding tube and then to carry him into the bathroom where I would hold him. Suspended. over the commode until he urinated and defecated. I would then lay him down on the living room carpet, where he would lie quiet and motionless.

Billy had been “saved” by a very high-tech, critical care unit of the hospital where he had been born. For the first year of his life he had been attended by highly skilled doctors and nurses, and then he was turned over to the care of his foster parents who were provided with a specially equipped van for transportation, as well as the financial support required to provide his clothing and the equipment needed to provide his nutrition. In addition to the care of his foster parents, he required the support, every morning and evening, seven days a week given by nurses and nursing assistants.

It has been years since I saw Billy, but there is no reason not to believe that now he is 21 years old and still in the care of foster parents and a support staff.

Almost everyone has directly experienced or knows someone who has experienced both the miracles and the horrors of American health care. Generally, though, discussion centers on the latter, the horrors: the medical errors, long struggles with insurance companies, misdiagnoses, the constant changing of physicians as employers opt for a cheaper form of coverage, the patient who was told that he would die in weeks but remains alive after years.

On and on and on the stories go, and Americans yearn for that time not so long ago when doctors and patients knew each other well and when the doctor was seen as a friend as well as healer and when medical costs could be measured in a number of chickens or sides of beef. But, of course, that time exists largely in imagination. That golden time in the past is probably as imaginary, as are many of the tales of today’s medical horrors. What cannot be doubted, though, is that the American medical system is broken, terribly broken and demanding of repair.

The Good Ol’ Days—and Today

There was a time when it made sense to speak of the "family doctor" who knew every member of the family, often from the cradle to the grave. There was a time when one could approach the doctor or even hospitalization without the fear of massive bills. There was a time when death came quickly after a brief illness or accident or infection rather than after months or years of pain, endless surgeries, and countless medications, each chasing the side effects of the latest pill.

That, though, was a time when the doctor was almost powerless to deal with medical matters that are today regarded as routine; wide varieties of illnesses, infections and injuries that used to kill but today are barely inconveniences. That was a time when families tended to stay in the same community rather than spreading themselves across the continent. By remaining close, they were capable of providing support when a member became sick or was injured and family members became part of the medical team. There may have been much that was wonderful and worth remembering about that time, but certainly there was much to which we would not wish to return.

Death tended to come early, and life expectancy in the middle of the last century was still only 54. Many people did live well into their 80s and 90s in those days, but they were the lucky ones. People died in the millions in infancy and childhood from a myriad of diseases. They died from measles, mumps, diphtheria, tuberculosis, polio, scarlet fever, and a host of other diseases that either no longer exist or that today may make one sick for a few days but rarely kill. People died of infections spreading from simple cuts on a leg or foot or hand. They died of injuries as simple as a fractured ankle or wrist from which a blood clot moved into the lungs. Medical science had not yet come up with blood thinners to eliminate the danger of blood clots. Every city had a rural hospital solely to house patients with tuberculosis or scarlet fever.

Modern American medicine, with all of its problems and failures, remains capable of curing illnesses and infections and repairing even injuries that would have brought death in just days 50 years ago. But is a price to be paid for the miracles of modern American medicine, and we remain a people who want all of the benefits but who are struggling with the costs, both financial and personal.

Historically, to be a patient was to be under the care of a physician. The patient's role was to be the largely passive recipient of the ministrations of the doctor. The patient's role was to present his or her symptoms to the doctor. The doctor's role was to diagnose the cause of those symptoms, to develop a plan of care to heal or to cure, and to direct the management of the care plan. In all of this the patient remained, for the most part, the passive recipient of this care.

This has been the traditional role of the patient for thousands of years: to be the passive recipient of whatever cares a physician, Shaman, or medicine man declared to be necessary. At the same time, a physician, until the last 30 or 40 years, was incapable of more than minor interventions into whatever the symptoms or trauma. Few of these illness or traumas are any longer threats to life given the power of modern medicine. Until the middle of the 20th century though, the majority of people died of disease, infection, or trauma that the physician was almost powerless to control or to in any way achieve a positive outcome.

Now the medical world has changed. Medical science has, almost overnight, developed a means whereby, short of massive catastrophic trauma, hardly anyone in any of the technologically developed countries on Earth needs to die prior to having attained the full human life span of 90 to 95 years.

More Surgery? Why?

When I was a brand-new nurse, still in the orientation phase of my job on the cardiac floor, I was assigned a gentleman recovering from open-heart surgery. He was 83 years old and suffered from an advanced dementia, probably Alzheimer's. His dementia was so advanced that he responded only to pain stimuli and then only with inarticulate groans and grunts.

He had lived for some time in a nursing home, and because he no longer was able to move voluntarily, his body had contracted into what can be best described as a fetal ball. His arms had contracted over his chest, and his legs had pulled up tight until his feet were touching his buttocks.

While in the nursing home, it was discovered that he had a cancer in his penis. He was therefore sent to the hospital for a penectomy (the removal of the penis). In the course of preparing him for that surgery, it was discovered that he had advanced heart disease. Therefore, he was prepared for and underwent open-heart surgery. I was to be his nurse during his recovery from that operation.

Each day the dressing over his chest incision had to be replaced and the incision inspected for possible infection. This was not an easy task. It required that I have two nursing assistants standing on either side of the bed to pull his arms away from his chest and hold them while I changed the dressing. As soon as they released his arms, they snapped forcefully back into their position across his chest. Through all of this, there was no response.

He was recovered and subsequently sent back to surgery for the penectomy. Three days later I was "floated" to the med-surge floor where he again became my patient. His penis had been surgically removed and the scrotal sac sutured into his lower abdomen. A catheter had been inserted through his abdomen into his bladder to drain his urine.

I questioned the surgeon as to why these surgeries had been performed. He responded, “It was wrong. But if I hadn't done it, somebody else would have. It’s what the family wanted.”

Restoring the Doctor-Patient Relationship

The changes that have occurred in medical practice over the last half-century have radically altered every dimension of medicine. Most importantly, they have changed and, in effect, have destroyed the relationship between the doctor and the patient which, from the time of Hippocrates, has been the foundation of medical care. The need to restore this relationship will be the subject of much of the rest of this book.

Historically the doctor was committed to only one thing: securing the well-being of the patient. Whether or not the physician received payment for his services, either in cash or barter, was, at best, a secondary consideration. The physician had an almost sacred duty to see first and only that his patients were cured of their illness, had their traumas repaired, and had their pain alleviated to the best of his ability.

Consider just the contrast between then and now in one of the most routine activities in medicine: going to an appointment with the doctor. In the “good ol’ days,” one sought the services of a doctor only because something was wrong: something was broken, burning, bleeding, oozing, bruised, or in pain. People lived by the old maxim, “An apple a day keeps the doctor away.” If you did everything you could to take care of yourself, then, with any luck you**,** might never have to see a doctor. The only reason to see a doctor was if you were sick or injured.

Contacting the doctor was often times accomplished by a simple phone call, following which the doctor arrived at one’s home. The doctor made a home visits because the doctor had a black bag. In that bank, the doctor carried virtually every medication and every medical instrument available. If the patient could not be cured with what was in the black bag, the patient

either got better or died. Questions of cost rarely arose as the doctor would be paid in cash or, not uncommonly, in barter.

Even hospitalization could rarely lead to costs beyond the reach of most patients ,as there was very little that could be done in hospitals that could not just as well be done at home. Surgery options were limited and all were crude and dangerous. There were very few available medications, only a tiny fraction of what is available today. And this was only a little more than half a century ago.

The impact of the changing world of medicine on society and on every individual is staggering. The costs of medical care have become ruinous. Controversy over how to reform the medical system dominates political discourse. Millions of people cling to jobs that they do not want only because of the fear of losing employer-provided medical insurance. The leading cause of personal and family bankruptcy is the inability of families to pay the costs of medical care. These are important problems and they are being discussed broadly and almost every sphere of discourse. But those problems are only peripheral to the intentions of this book.

This book is dedicated to helping people understand that the ultimate responsibility for health belongs to each individual, not to the doctor and the medical system. It is dedicated to assist you, the reader, first, to understand the foundations of lifelong health and, second, to understand the increasingly important role that you must play in the medical system.

This book is oriented to a vision for the future of medical care.[1] This vision entails changes in every area of medical practice: governmental (the role and function of the government), private (the roles of private insurance and of employers), practice (the roles of primary care doctors, of specialists, and of adjunct personnel such as nurses, nurse practitioners, and physician's assistants), and the new roles of the patient.

The U.S. System—*Not* a Health Care System

Note that in the title of this chapter, "The American Medical System: Something Has Gone Terribly Wrong," I do not refer to the American "health care" system. The United States does not have a health care system. The United States has never had a health care system. What it has is a medical system—a system designed to cures sickness and repair injury. And the system is very good at doing those things. But the truth of the matter is that health has very little to do with American medicine. In fact, it can reasonably be argued that we *disincentivize* health in the American medical system—that is, doctors are actually discouraged from keeping people healthy.

Think of your personal doctor. If your doctor is really good and spends time and energy listening to his patients and then teaching them and helping them take charge of their own health—thereby making all of his patients healthy—your doctor is going to be bankrupt. We do not pay doctors for having healthy patients. We pay them for fixing things that are broken, burning, bleeding, oozing, or in pain.

Consider your local hospital. A serious outbreak of health in your hometown and your hospital is in deep trouble. We do not reward hospitals for creating healthy communities.

Consider this, too. Most doctors work for large corporations. They no longer finish medical school and return to their hometowns and nail their shingle up on the front porch and go into practice. No. Today'' physician is the employee of a large corporation that is worth millions and often sometimes billions, of dollars. It owns hospitals and clinics and surgery centers and urgent care centers. It hires tens of thousands of people. It exists for one reason: to make money.

Each and every component of the system is expected to provide a return on investment. And the doctor is a component of the system.

Patients have become, to a large degree, the raw material out of which the corporation generates profit. Even not-for-profit hospitals evaluate their success as well as the programs they offer primarily in terms of profit: of the degree to which their revenues exceed expenses. Emphasizing the shift to managing medical care using a business model is that today the doctor has become the "provider" and the patient has become the "consumer."

One of the most dramatic changes in the American medical system has been the demotion of the primary care doctor. The primary care doctor is the doctor the patient sees when entering the medical system. That's the doctor known in the mythology of the American medical system as the "family doctor." That's the doctor portrayed an early television and radio as a close family friend, full of wisdom, available at a moment's notice and almost a member of the family from the cradle to the grave.

With the advent of modern corporate medicine, the family doctor no longer exists. In his place is the doctor who sees 25 patients every day. In his place is the doctor whose primary job is the handle the most mundane and routine medical complaints and to refer everything else on to a specialists. In his place is the doctor whose relation to you is determined by your employer's decision to go with the lowest cost provider of medical care. To make matters worse, that decision may be reviewed every year to two with the result that the patient has a new doctor just that often.

While specialists' salaries have been increasing rapidly over the past 20 years, the salaries of primary care physicians have been declining. Medical schools find it increasingly difficult to recruit students who want to go into primary care medicine. Primary care medicine is the bottom end of the totem pole. Between 1997 and 2005, the number of U.S. medical School graduates entering primary care medicine dropped by 50 percent. More and more the primary care doctor has become merely the gatekeeper who provides referrals to the specialists. And since the primary care physician's compensation is often determined by the number of patients seen, it becomes far easier and less costly (for the doctor) to send a patient to a specialist rather than to take the time to explain to the patient's the nature of a problem and what the patient can do herself to deal with it and to prevent its recurrence.

This is a tragedy. It is primary care medicine that can and must be the center of medical care. It is the primary care doctor who must be given the opportunity to know his patients and to have his patients know him. It is the primary care doctor who can teach about issues of health and prevention. It is the primary care doctor who is the key to building a more healthy society and, perhaps, of equal importance, to controlling the disruptive destructive costs of medical care. In a time when the costs of medical care threaten patients, families, and society itself, it has been demonstrated that the degree to which primary care medicine is available, costs go down, patient satisfaction goes up and outcomes improve. [2]

The American medical system is broken. Possibly it is broken beyond any reasonable hope of repair. And yes, we must each of us understand that system before it can change or before it can be, for us, a genuine health care system. If you're interested, I say a lot more about this in Part V of this book, "A Vision for the Future of Medical Practice in the U.S."

Finest Health Care in the World?

By the way, we are constantly being told that America has the finest health care system in the world. We are told that people come from all over the world to participate in America's

health care system. We are assured that we certainly would not go to Canada for our medical care. In Canada, we are told, people are dying because they cannot receive medical care. In Canada, we are told, people have to wait a long time before receiving even basic medical care. In Canada, we are told, people leave in large numbers to come to the United States to receive medical care, which is both quick and better.

Let's consider some facts. In Canada, life expectancy is greater than in the United States. In Canada, healthy life expectancy is greater than in the United States. In Canada, emergency care is equal to or better than the emergency care provided in the United States. In Canada (we are not usually informed of this), the per capita costs of medical care are substantially less than in the United States.

It is been suggested by some that saying these things is wrong, perhaps even unpatriotic. The facts, however, cannot be denied. The World Health Organization is the source of statistics through which we can compare medical care in the United States with medical care in all the other countries of the world.[3] The World Health Organization tells us that the United States ranks 27th among developed nations in life expectancy and that it ranks 37th among developed nation in healthy life expectancy. In 36 other countries, including some Third World countries, people stay healthy longer than they do in the United States.

To point this out is far from being unpatriotic. Given the tens of millions of Americans who have no access to medical insurance, government or private, and the tens of millions of others whose medical conditions are, in principle, preventable, this is a criticism that is intended to speak to those who can make a difference—a difference that will make America even greater than it is.[4]

Discouraging Statistics

But let's look at some facts. The United States currently spends two to three times more per capita for health care—that's two to three times more—than any other developed country on the planet. And yet the United States ranks 27th in longevity. In 26 other countries, people live longer on average than they do in the United States. Even more significantly, the United States ranks 37th in healthy longevity. There are 36 other countries, including some Third World countries, where people stay healthy longer than they do in the United States. The United States ranks close to last among developed nations in infant mortality. It ranks at the middle or below the middle in virtually every measure of medical outcomes. And yet we spend two to three times more per person for medical care in the United States than anybody else.

To put it most simply, there is very little money in health. Our medical system is not designed to promote health. It is designed to cure sickness and repair injury. The dollars we spend for medical care are dollars spent almost entirely to cure and repair, not to promote health. Primary care medicine, which has, throughout most of the history of medicine, has been exactly what its name says, "primary" medical care. But with the creation and growth of specialty medicine, primary care medicine has lost its preeminent position. Today the primary care physicians, live at the bottom of the medical pecking order. Both in terms of prestige and income, the primary care physician is at the bottom of the ladder. The fame and the wealth go with the specialties. But the specialties are designed to deal with patients who are either sick or injured. They have little or nothing to do with patients who are healthy and who hope to remain that way.

Out-of-Control Costs

The $3 Circumcision

A friend, Rick, came to me about seven years ago because he heard I was giving a talk on being healthy. He told me he had something I might be interested in. He showed me the bill his mother received when he was born in a Green Bay hospital in 1942. It was a simple 5-x-7-inch sheet of paper, largely hand written (see below). At the top was printed “St. Mary's Hospital,” “Name,” “Date,” and under that, the rest of the bill was handwritten. My friend’s mother had her baby and spent seven days in the hospital. It was perfectly normal in those days for a mother to remain in the hospital for a full week, healing, bonding, resting, and learning. Her room cost was $5.00 per day. The delivery room was $7.50. Her medications were $2.75. My favorite line in the whole bill was the bottom line: "Circumcision, $3.00.” Now, there are a lot of things I don't know, but I do know that you can't get a good circumcision today for three dollars.

Rick’s mother had gone into the hospital, had a baby, and spent an entire week bonding, healing, resting, and learning. She went home with a bill for $67.25. You say, "Yes, but that was in 1942!" And yet, if nothing had changed from then until now except inflation, a woman should be able to enter a hospital, have a baby, spend an entire week, and go home with a bill for about $950.

I check at my hospital every so often. The last time was about six months ago. A young woman came in to have a baby on Monday morning. She was not allowed to come into the hospital until she was ready to deliver. I remember that when our daughter, Elizabeth, was born in 1967, Rosalie had called her doctor and told him her water had broken and that she was ready to into labor at any time. She asked if it was okay if she just came in to the hospital. Her doctor responded that that was just fine. The young woman to whom I just referred called her doctor and told him that she was having contractions.

He asked, “How far apart are they?”

She responded, “Well, right now they are about 12 minutes apart.”

He responded, “Call me back when they are five minutes apart.”

She was not allowed to come into the hospital until she was truly ready to deliver. She came in on Monday morning had her baby, and on Tuesday afternoon, and the mother and baby were discharged from the hospital with a bill for $5,000 that did not include the cost of the doctor. The system is out of control.

Life Expectancy—A New Ballgame

Each day we live increases the odds that we will live longer. Let me illustrate.

Actuarial Science and Me

When I was 50 years old, if I decided that I wanted a life insurance policy, I would have called an agent. With virtually the speed of light, he would be at my door. He would have a small book of actuarial tables and he would say, “Okay, you're a 50-year-old Caucasian male. Your life expectancy is 68.” He would then write a life insurance policy figuring that if I died at the projected life expectancy of 68, the company could pay off the policy and still make a profit. If, however, I was 60 years old when I called that agent, his actuarial tables would have told him that I was now expected to live to 74.

Again, premiums would be developed based on the policy having to pay off in 14 years. Now, in 2009, I am 73 and that same policy will require that the premiums be paid and the profit generated in about 10 years. That is, my life expectancy is now 83. And so it goes.

I was born in 1935. That year life expectancy in the United States was 54. That's how long people lived on average, 54 years. Today our national life expectancy is approaching 80. Consider that it took the entire history of the human race until 1935 to get life expectancy up to 54 and now, in one lifetime, we've taken it to nearly 80. That's truly remarkable. It's even more remarkable when we realize that if we average our life expectancy together with that in the 26 countries where people live longer than we do and then average in all of the other nations on earth, a baby born today can expect to live just 46 years. But here in the United States our life expectancy is approaching 80.

Here's the kicker: Most Americans can now expect to live 90 to 95 years. You say, "But why? Life expectancy is only 80." The answer is that they have already survived the most dangerous parts of life. They didn't die in infancy, far and away the most dangerous part of the lifespan. They didn't die as a children. They didn't die doing stupid teenage things. The chances are very small that you anyone in their thirties and beyond will get sent off to fight a war somewhere. No, the odds are that most everyone alive today is are going to live 90 to 95 years. Let's examine how and why.

Every living thing on planet Earth has a life span. The giant Sequoia has a lifespan of 2000 years or more. The Galapagos tortoise lives 175 to 200 years. Dogs live for 10 or 12 and cats tend to get an extra year or two. Nobody keeps a fruit fly for a pet. It has a lifespan of about two weeks. So you buy your pet fruit fly and bring it home. You build it a little tiny house. You start teaching it tricks and in 14 days it dies. Not good. The human lifespan is 90 to 95 years; sometimes a little less, sometimes a little more. When it happens that somebody lives to 100 or 102 there is almost always a feature article in the local newspaper because that's news. If everybody were to live that long it wouldn't be news.

It was only in the 1940s that antibiotics were discovered. Antibiotics are probably the greatest miracle in the history of medicine. With their discovery, almost overnight disease and infection ceased to be significant mortality factors for us. Virtually nobody alive today is going to die of measles or mumps or chickenpox or diphtheria or polio or tuberculosis. Hardly anybody is going to die of scarlet fever or other diseases that take the lives of hundreds of millions of people on this planet every year.

Only a few people will die of infection. Our grandparents and great-grandparents who experienced a bad cut on a hand or foot—a cut into which infectious organisms migrated and then migrated into the bloodstream and into the rest of the body—died. There was nothing the doctor could do about it. Today we are all immunized as infants, and literally thousands of medications have been created to control disease and infection. All over this planet people die by the millions every year of diseases that none of us in the U.S. even think about.

The Flower Pot Miracle

In early June 2007, I was moving a flower pot. It slipped and broke. I attempted to scoop up the potting soil and in the process, a shard of the pot cut my left ring finger. I washed the finger thoroughly and put bandage on it and then left town for two days to make presentations. By day two, I realized that the finger had become infected. As soon

as I returned to Green Bay, I went to my doctor to have the finger checked. It was a staph infection, and I spent six days as an inpatient receiving IV antibiotics. The infection was cured. Had that same incident occurred 50 years ago, the odds are very good that I was a dead man.

It Is Very Hard to Die!

Further, beginning in the 1950s, we began to create surgical technologies of unbelievable sophistication. I am a cardiac nurse. At my hospital, we do an average of 15 open-heart surgeries each week. "Open-heart surgery," also known as "coronary artery bypass graft surgery," or "CABBAGE," is one of the most-performed surgeries in the United States. But nobody ever woke up in the morning and said, "Geeze, it's cold, it's rainy, and I'm bored. I think I'll have open-heart surgery." No.

People have open-heart surgery when their heart disease is so advanced that they are going to die. They are probably already on cardiac medications. They probably have already had an angioplasty. They may have stents holding one or more coronary arteries open. But their heart disease has advanced, and unless they come in and surgeons open their chest and sew new arteries on their heart, they are dead. As a result, millions of Americans are walking the streets with that railroad track scar down their chests. Forty years ago they were all dead.

It is very hard to die!

The Corn Chopper Miracle

Some years ago I admitted a 72-year-old farmer to hospice. He died of lung cancer because he was a smoker and that's what smokers tend to die from. As I did the physical assessment required for his admission, I discovered that completely encircling the top of his right arm was a scar, the most horrendous a scar I have ever seen. I asked him what happened. He responded, "Oh, about seven or eight years ago, my son I were a working out there in the south field. I got my arm caught in the corn chopper." It severed his arm. Sliced it off! At any other time or place in history this man would have been dead where he dropped. Not now, though. His son reached into the tractor and pulled out a cell phone. He punched 911. A medical helicopter came to the farm picked up the farmer and his arm and took them back to the hospital, where the arm was reattached. The arm never did work very well. But the man did not die of shock. He did not die of infection. He did not die of blood loss. He died of lung cancer because he was a smoker.

It is very hard to die!

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[1] The details of this vision will be set forth in Part V, "A Vision for the Future of Medical Practice in the U.S."

[2] 'Outside the Beltway, 1 November, 2007, Joyner, James, "Primary Care Physician Shortage," http://www.outsidethebeltway.com/archives/primary_care_physician_shortage/

[3] World Health Organization, See, http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf

[4] Approximately 70% of all of the costs of medical care in the United States are for the treatment of what our common in principle at least, preventable conditions.