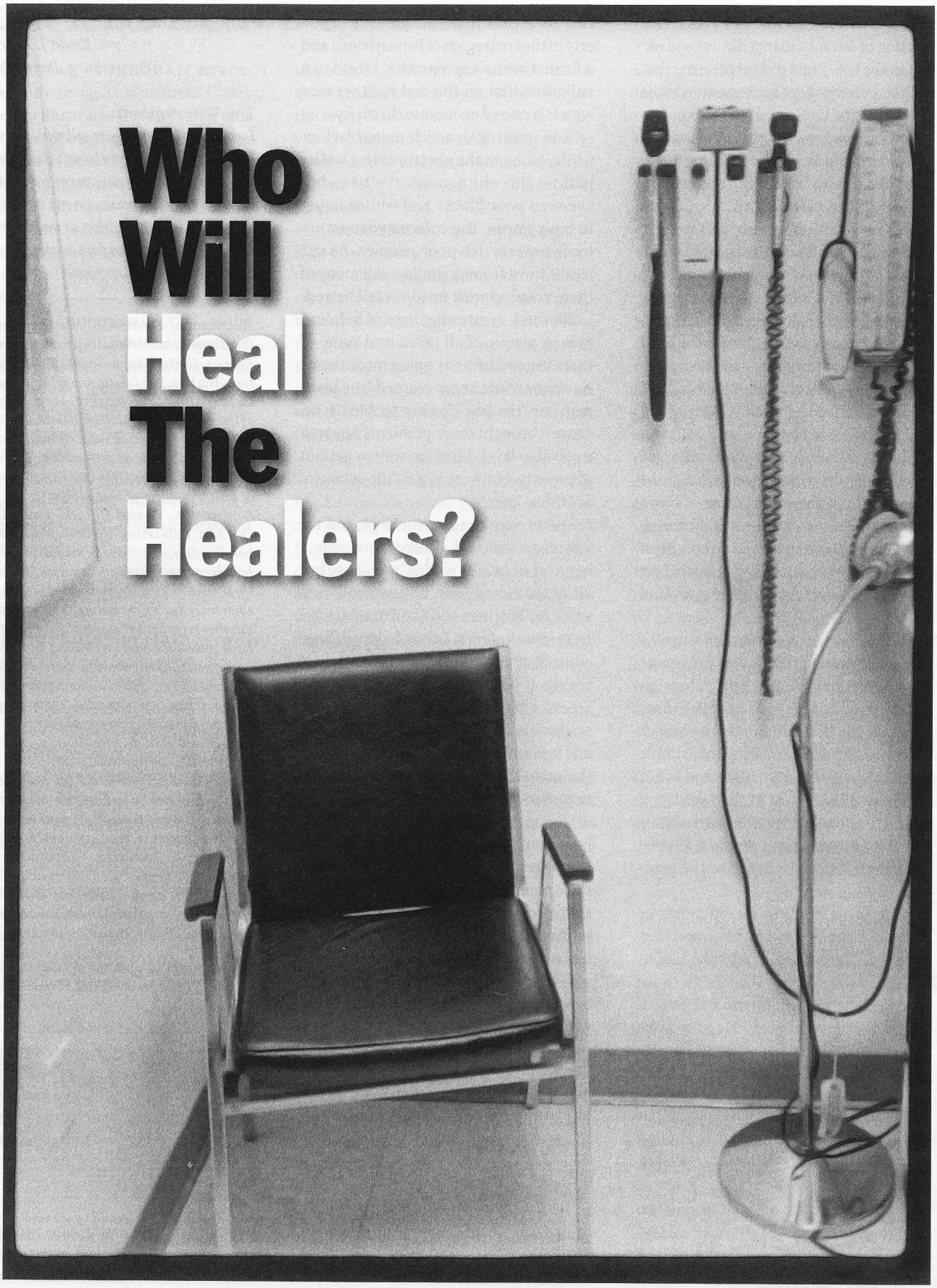
Who Will Heal The Healers?



ROY ARENELLA

Pamela Wible On What's Missing From Healthcare Reform

JAMIE PASSARO

As a girl Pamela Wible had recurring dreams in which she'd find dying people, bandage them, take them home, and nurse them back to health. She knew even then that she wanted to be a doctor. Wible became a family physician, believing it would allow her to serve not just her patients but also their families and communities. At the age of thirty-six, however, after working in six different clinics in ten years, Wible was ready to quit. Rushing through thirty office visits a day, she wasn't meeting her patients' needs — or her own — and she grew so depressed she stopped working.

Wible's depression lasted six weeks before she was, as she recalls it, "jolted out of bed" with a vision of how healthcare could be. Within weeks she led a series of healthcare forums in Eugene, Oregon, where she lives. The ideas gathered at the forums became her business plan, and within months she'd launched a clinic designed entirely by her community.

At her two-room office in the basement of a wellness center, Wible is not just the doctor but also the receptionist, the nurse, the bookkeeper, the insurance biller, and the janitor. Yet she works only part time, sees patients for up to an hour apiece in a living-room-like setting, and makes house calls. She is relaxed and quick to laugh. She even finds time to travel the country and encourage other doctors to leave what she calls "assembly-line medicine" and to create clinics in collaboration with their communities.

Wible's not alone in her dissatisfaction. A recent Physicians' Foundation study of twelve thousand U.S. primary-care physicians found that 78 percent of them believed medicine was either "less rewarding" or "no longer rewarding," and 76 percent said they were either "overextended and overworked" or "at full capacity." Another study shows that physicians can experience "empathy burnout" after seeing just ten patients in a day; most doctors see three times that many.

Wible was born in Philadelphia, Pennsylvania, to a lesbian psychiatrist and a Jewish medical examiner. Her parents' marriage didn't last, and she spent part of her childhood in Philadelphia with her father and part with her mother and her mother's partner in rural Texas. She says living with two lesbians "on the buckle of the Bible Belt" forced her to develop a sense of humor. With her father Wible spent much of her time in the morgue. She also accompanied him to his part-time jobs at a jail and a methadone clinic, where he introduced her as a "doctor-in-training."

Wible attended Wellesley, a liberal-arts college for women, and went on to medical school at the University of Texas at Galveston, where she protested the vivisection of dogs, believing that the same lessons could be taught in humane ways. She started petitions, but few students signed, because, they told her, they feared they would be "blacklisted." She was eventually granted exemption from the vivisection labs. Wible describes this as the first of many times in her life that she would stand up to authorities, express her beliefs, and persevere.

Wible is as optimistic about changing the face of healthcare in the United States as she is angry about the current system, calling it "predatory" and "submerged in a putrid stew of greed, bureaucracy, and unethical leadership." She's currently writing a book with the working title Doctoring for Democracy.

I met Wible two years ago, when I was looking for a new family physician. At the end of my first hour-long appointment, she pointed out that the plastic sippy cup I'd brought for my toddler contained harmful chemicals. I was both shocked and thrilled at the level of attention and care. During my husband's first appointment — for a cold he couldn't shake — Wible took stock of his diet and recommended more fruits and vegetables, especially leafy greens like kale. He was skeptical at first but now makes kale smoothies most mornings and hasn't been sick in more than a year.

Wible told me how, after Hurricane Katrina in 2005, she flew to Houston, Texas, of her own accord, despite official warnings that physicians should not "self-deploy." Before she went, she had been working on a presentation about community-designed ideal medical practices, and the irony of the situation had hit her: "Here I was writing about how to transform our healthcare system. Meanwhile I was waiting for official instructions to tell me the right thing to do. Don't we all know the right thing to do?"

Entering the Astrodome, Wible and a colleague were greeted by a tired young physician who asked them to take charge of the medical clinic. Wible didn't feel equipped but worked the night shift for a week. Her resting heart rate increased fifteen beats per minute and didn't return to normal for weeks afterward. She believes this is how most doctors are living: in a constant state of stress. A month after she returned to Eugene, Wible received official word that she was free to volunteer.

Passaro: Before you started your own practice, you worked at what you call "assembly-line" clinics. What was that like?

Wible: I didn't have time to connect with my patients. They had to fight through the phone system to get an appointment, and when they finally got in to see me three weeks later, they had maybe fifteen minutes to get all their questions answered. Sometimes we would rush through one or two main concerns, but there were still five more we didn't have time to discuss. They would speak fast to get all their issues on the table. I didn't feel that I could ask questions about patients' lives unless they were the last patient of the day and I stayed late, or maybe if they came around noon and I was willing to skip lunch. I rarely took bathroom breaks, just so I could spend more time with them. That was the price I paid to develop real relationships with my

patients.

I was extremely disheartened, because I felt I was destined to be a doctor, but I couldn't sustain my enthusiasm on the assembly line; it was such a dehumanizing experience. I was tired of interrupting crying people to say, "Sorry, we're out of time." I wanted to be kind to patients, even if it meant a huge cut in my salary. Many doctors feel this way. I've met several female physicians who are ready to quit medicine and find other work.

Passaro: Does the "assembly line" affect women more acutely than men?

Wible: I think so. Nothing against men: it's just that Western medicine was designed by men, and men are more willing to turn healthcare into a competitive sport of who can see the most patients per day. But we *all* had to play that game; the rules were drilled into us to the point that, if I had a no-show, I'd worry, *Oh, no, I'm down one.* One employer gave us monthly color-coded charts that compared us to our peers in terms of speed and number of patients seen. They spent a lot of money on special software for these slick report cards. It took me hours to figure out how to read them. Ultimately the message was "You're a shitty doctor." That's the kind of intimidation used to control physicians.

The pressure to see as many patients as possible is driven by high overhead. In one job my overhead was 74 percent. So if I rushed thirty patients through in a day, twenty-two of them were to pay the overhead. There was no time to slow down, no time to think, no time to care.

Passaro: It must have been dispiriting to have so little time for your patients.

Wible: I was physically, mentally, and emotionally exhausted. When I was out in the world at a grocery store, for example, I sometimes saw someone I thought might be a patient, but I wasn't sure, because I hadn't had time to get to know them during the office visit. So I used to hide behind my grocery cart to avoid them. I felt bad that I couldn't even remember my patients' names.

Passaro: How is it different for you today?

Wible: Now my practice is relationship based. I'm never thinking, *How many patients did I see today?* Just the other day I was in the grocery store, and there was one of my patients in front of me in line and another behind me. Plus the cashier was a patient too! We were all so happy to see each other. We embraced, and I snooped in their carts to see what they were buying. That's what it's like when you're a community doctor. I ride my bike to work, and people wave to me. I feel as if I'm in a Norman Rockwell painting from the 1950s. [Laughs.]

Practicing medicine looks so complicated. It doesn't have to be. Providing care is actually simple.

Passaro: What do you offer now in your practice that you didn't before?

Wible: The most important therapy I deliver is a human relationship. I'm not doing anything controversial or woo-woo. I never thought of myself as practicing alternative medicine until a colleague pointed out that spending time with patients is now "alternative." We live in a world with all this electronic communication, but is anyone sitting down for an hour and making eye contact and talking, relating on a spiritual, emotional, and physical level? When patients come into this office, it's a refuge from the frenetic outside world. They tell me things they might not have told anyone else in their lives — not even their spouse. They open up to me.

PAMELA WIBLE

Another thing I do that I didn't have time for before is talk about medicinal foods and dietary prevention. You can wait to get bad news, or you can actually heal yourself every day by eating the right foods — which, by the way, don't cause side effects like liver failure or five-hour erections. [Laughs.]

In medical school we received only two hours of nutrition education. I pretty much had to discover, through my own research in the medical library, how diet can heal or prevent diabetes, hypertension, and high cholesterol. A plant-based diet is essential to human health. It's disgraceful that many people in this country don't have access to fresh fruits and vegetables, only junk at convenience stores. Some poor neighborhoods don't even have grocery stores. We do this to people, and then we're angry when they develop diabetes. When I cared for Katrina refugees, everyone over thirty was on insulin.

Passaro: Can you offer an example of how you approach certain health problems now versus how you did when you were in the factory system?

Wible: One little girl came into my office because she was urinating frequently at night. This had started when she'd moved in with her dad and stepmom. In a standard clinic, if a patient has urinary frequency, you automatically start with a urinalysis. But because I could take time to talk with her, I realized that her anxiety about living with a new mother was causing her symptoms. I told her to tell the adults when she wasn't comfortable about something. I allowed her to access her feelings and speak her truth. Days later her symptoms disappeared. I didn't even have to touch her.

I've recently begun to teach my patients how to examine their partners' bodies. A lot of women are afraid to examine their own breasts, so I instruct them and their partners on how to do it. I've taught them how to examine ovaries and how to screen for melanoma, which is most likely to start on the back. It's hard to examine your own back, so it's often the partner who discovers a suspicious mole.

Passaro: What advice do you have for patients who don't have the luxury of hour-long doctor visits? How can they foster better communication with their doctors?

Wible: They should probably follow the advice of an elderly woman I know. She went to her doctor for one of those fast visits. When the doctor rushed in, she asked, "How much time do we have?" He said ten minutes. She said, "Well, I want

you to take off your coat and hang it up, and I want you to lean forward and look me in the eye and really listen to what I'm saying before you answer my questions." You have to get physicians out of their robotic, technical mode and into a state of being fully present, which I think most doctors are still capable of attaining.

Passaro: Why has medicine changed so much since the days of house calls and family doctors?

Wible: In the last fifty years all these third parties have inserted themselves into the sacred patient-physician relationship: insurance companies, pharmaceutical companies, government regulators, technology — "advancements" that we don't want and that might not even be good for us. Many of the tests we can order now only make people more anxious than they were before. How is that helpful? We get a lot of information that we don't need, but we're not even gathering information about lifestyle and nutrition. We don't ask basic questions like "How's your life going?"

Passaro: How did the medical profession get away from individual practice?

Wible: I trace the industrialization of medicine back to two programs: employer-sponsored healthcare, which started just after World War II; and Medicare, which started in 1965. Before those programs, doctor-patient relationships were more transparent and more personal.

Then major employers started going with complex insurance programs, such as health-maintenance organizations [HMOs] and preferred-provider organizations [PPOs]. The physician was put in a position of either signing on to work in a big group or else losing any patients who worked for, say, Ford Motor Company. The preferred-provider system was also sold to doctors with a promise of more money for less work, because of less overhead. Doctors wouldn't have to worry about staff and business and paperwork. There were slick brochures and free trips to Hawaii when you signed up. You can see how doctors got seduced.

There's an element of prestige when one belongs to a big group and can say, "I'm a preferred provider." We doctors basically want the American dream like everyone else. After all the effort and expense of our education, we generally feel we deserve some comfort in life. So when these third parties promised us the world, it was pretty easy for us to fall for it. But then some administrator on the fourth floor turned up the speed on the assembly line, and before we knew it, we were churning patients through and skipping bathroom breaks.

And with the big providers came an increasing complexity that, it seems to me, was created by bureaucrats to justify their own existence. At a certain point you had more complexity and headache than service being rendered.

Now, instead of walking or biking to see your neighborhood doctor, you have to drive across town to a big clinic, park in a parking garage, and sit in a cafeteria-sized waiting room. This isn't what people want. People want home visits. They want it to be the way it used to be. And there's no reason why we can't have that now.

I couldn't sustain my enthusiasm on the assembly line; it was such a dehumanizing experience. I was tired of interrupting crying people to say, "Sorry, we're out of time."

Passaro: Are there not any advantages to group practices?

Wible: There is less need for the physician to deal with business and administrative tasks. Plus co-workers become sort of a family. You can easily consult with colleagues: if I saw a rash on a patient and wasn't sure what it was, I could talk to the dermatologist down the hall. You get retirement benefits and group health insurance. And when I was one of twenty family-practice doctors in a group, I was on call only once every twenty days. Of course, on that day I was slammed because I was responsible for all twenty doctors' patients. But for the other nineteen days I didn't have to think about it.

Passaro: What inspired the design of your current practice?

Wible: My original vision was that citizens would come together and articulate what they desired in healthcare. I wanted to facilitate the design of a dream clinic. I woke up with this idea on December 7, 2004, and held my first community forum on January 20, 2005. About thirty people showed up. I did eight community forums in all and got about a hundred pages of written testimony, which became my business plan. Eugene is a pretty creative town, and those pages were overflowing with wonderful ideas. We were open for business by April 1, just a few months later.

Passaro: What are some of the changes people wanted most?

Wible: People said that they wanted to be heard and to be treated as a person, not as a commodity. Simplification was another theme: people wanted to eliminate the medical assistant who weighs and measures and takes notes that the physician doesn't read, anyway. Many people wanted to make sure that nobody would be turned away for lack of money. They wanted their doctor to be willing to barter, which I am.

Passaro: What are some items you've accepted in trade from patients?

Wible: Dog care, carpentry, gardening, massages, cleaning services. Local artisans have donated the use of a kiln and glass-fusion classes. I donate many of these traded items to other patients in need. Then there's the delicious homemade bread and homegrown produce. I will work for food.

Passaro: Could your methods be adopted by specialists, or is this just for family practice?

Wible: There are specialists already doing this. This is nothing new that I created. Most psychiatrists, chiropractors, and massage therapists have always had small practices.

One of the problems for specialists — especially high-risk specialists like obstetricians and neurosurgeons — is that they pay the highest malpractice-insurance premiums: $200,000 or more a year. It's rough for them.

Malpractice suits are a big problem. We have attorneys on

TV commercials asking, "Do you have a child with cerebral palsy?" They convince people that their OB-GYN did something wrong during the prenatal period. And you can understand why this is so tempting for people. If your child has a devastating illness, the treatment is probably going to cost more than your family earns in a year. Even if you love your doctor, when your attorney tells you that a lawsuit will keep you from filing for bankruptcy, you might be willing to sue.

Passaro: Is malpractice the Achilles' heel of a small practice like yours? Could a single suit bankrupt it?

Wible: Not as long as I have insurance. Luckily for me, malpractice insurance is inexpensive in Oregon compared to the rest of the country. Doctors can also get discounts for working part time and taking risk-reduction classes. My first year in solo practice, I got 86 percent off my total premium. And I'm running a practice where patients get what they need, which minimizes the chance of a malpractice suit.

The only Achilles' heel I can think of is that, once you get rid of all the layers of complexity and streamline your practice, you're going to expose your own flaws. If your office isn't organized, you can't blame the nurse or anyone else. It's your fault. I'm learning a lot about myself.

Passaro: How do you handle insurance-company rules and restrictions?

Wible: About 80 percent of my patients have insurance, and I bill their insurance through a free online clearinghouse. I won't work with abusive or highly dysfunctional insurance companies. Some patients have been mad at me for not accepting their insurance, but they should be angry at their insurance company for making it so difficult to deal with them. The patients who don't have insurance receive a 40 percent discount if they pay at the time of service, which saves me the administrative burden of having to bill later. Most people take advantage of that. Some people can't afford to pay, so we just do whatever makes sense. I never turn anyone away for lack of money.

Here's one big problem, though: I've had doctors tell me they want to practice medicine the way I do, but because they have health problems of their own, they are excluded from affordable health-insurance plans. So doctors are trapped in the medical mill because they can't afford to buy their own health insurance. That's sickening.

Passaro: How do you reduce costs so much across the board?

Wible: I've reduced costs by humanizing the experience. People want to be cared for, which doesn't necessarily require lab work or MRIs. Most of the patients I see can't handle the pace of modern life: it's the cause of their stomach pain or high blood pressure or panic attacks. Sending them through a medical mill for more tests doesn't really address the root of their problem.

I think anything will work as long as we establish human relationships with each other. I don't care if it's private or government run: if the foundation is not ethical human relationships, then it will fall apart.

I'm wary of technology. I know it's cool and exciting, but do we always need it? Oprah Winfrey was thrilled about the sixty-four-slice CT scan when it came out. Demand for the test immediately increased. The scan can show you all these amazing images of the inside of your body, but it also increases your risk of breast cancer. It's ridiculous that we have people asking for tests that they don't need, tests that could actually harm them. Once I explain this to people, they stop asking for the test. But if I had less time, it might be easier just to order the test and get the patient out of the exam room.

Passaro: Do you take Medicare?

Wible: No, the administrative hassle is oppressive. I tried, but after a year I gave up. I still see my Medicare patients, of course, but not all doctors can afford to. A recent Physicians' Foundation survey revealed that 36 percent of doctors lose money every time they see a Medicare patient. I'm not willing to support an insurer that puts my fellow doctors out of business.

Passaro: Why is it so expensive for doctors to accept Medicare?

Wible: Medicare's heavy administrative burden requires higher staff-to-physician ratios, so physicians must hire more staff, which increases overhead, meaning doctors have to charge more. It's a vicious cycle.

Passaro: If Medicare is so dysfunctional, how does it continue to exist?

Wible: Doctors don't want to turn the elderly away, so they keep accepting low reimbursement and just hang on somehow and put up with it. Medicare does provide great service to patients. It is just onerous for physicians.

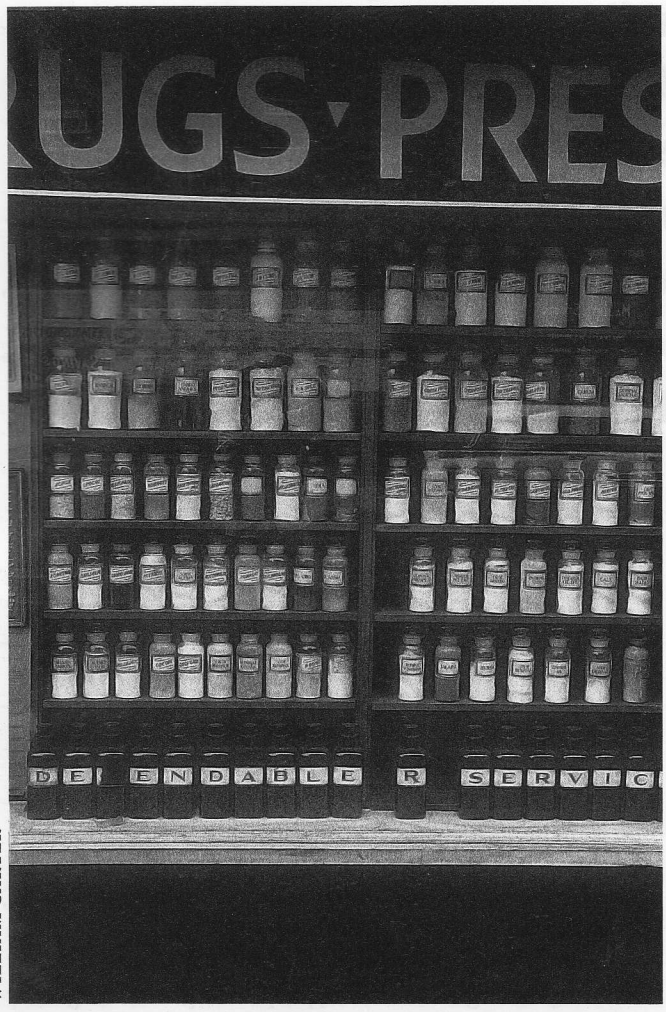
Really, when you look at the facts, patients and physicians should be standing in solidarity on this instead of being pitted against each other. The patients think the doctors are greedy, the doctors think the patients are needy, and the legislators want to preserve their salaries and their own health benefits.

Passaro: What do you think of President Obama's healthcare plan? Is it a step in the right direction?

Wible: Obama is moving in the right direction. Everyone deserves healthcare. It's a no-brainer. We are all in this together. But ultimately we cannot legislate ethical behavior. We can write thousand-page reform documents and give incentives for right behavior, but the human brain is sneaky and will always find self-serving loopholes.

Passaro: Much of the concern about universal healthcare is that it will create more bureaucracy. Do you think we could avoid this?

Wible: I think anything will work as long as we establish human relationships with each other. I don't care if it's private or government run: if the foundation is not ethical human relationships, then it will fall apart. And we must keep it simple. Complexity breeds confusion.



WILLIAM CARTER

We just need to start over again. There is no way to adjust the current system to make it work. Of course a lot of the population is in favor of providing healthcare for people who don't have insurance or are underinsured, but will this slow down the treadmill? No. The treadmill will probably move faster. Will this address the quality of your care? No. Will this address whether you're going to get more time with your physician? No, because she or he is probably going to be glued to a complicated electronic medical record. We need to focus on the quality of care and not just ask, "Who is going to pay for this?" There's a lot of money to be made in healthcare. It's to the advantage of the people who are making the most money now to keep asking, "Who is going to pay for this?" They want to get their portion of the healthcare dollar. But healthcare at its core is really a relationship between the physician and the patient. This relationship has to come first, before everything else.

Passaro: Wouldn't any system that depends on people's behaving ethically be vulnerable to abuse?

Wible: Yes, but we have to try. We have to believe in each other and demonstrate right behavior. I'd like to see our society change the rules of the game. The winner at the end of the day should be the best humanitarian, not the person who hoarded the most money.

Passaro: How do you envision that working on a national scale?

Wible: I think it's hard to dictate what's going to work on a national scale. President Obama says this. He's constantly trying to empower people at local levels. If a community would take him up on this and align its healthcare system with its needs, it would have something far better than what the government could provide. And yes, communities do need funding, but ultimately it's cheaper to keep our dollars local instead of the government handing them out at the top and everyone taking a cut on the way down to the local level.

Passaro: If you had President Obama's ear for an hour, what would you tell him?

Wible: I'd share success stories from innovative physicians and communities all over the country. No complaining. He's heard enough complaints.

This isn't wishful thinking, or "someday we could have an ideal healthcare system." Some of us are doing this now. Politicians inside the Beltway are so insulated. I'm not sure Obama has ever thought about the concept of a community-designed ideal medical clinic. I'd like to turn him on to local solutions to our national healthcare crisis.

How about a program in which people who are overinsured and get approved for tests they don't need can donate their coverage to people who are uninsured who actually need the tests? For example, if you've been in a monogamous relationship for thirty years and you've never had an abnormal Pap smear, you're at a very low risk for contracting the human papillomavirus, a factor in nearly all cervical cancers. In this situation wouldn't you want to donate your Pap smear to a girl in the inner city who might actually have this virus that could kill her before she's twenty? Give ordinary Americans a chance to be heroic in their everyday decisions. People yearn for this.

Most of our healthcare dollars are spent on end-of-life care. I think people at the end of their lives don't need another MRI, but they would give anything for someone to sit with them and hold their hand. They need to know their lives mattered.

Passaro: Let's say President Obama hired you as a healthcare advisor. What would you do?

Wible: I would go into communities and train people to create their own healthcare clinics. We don't have to wait for a disaster like Hurricane Katrina for people to help their neighbors. Why not come together before a catastrophe? I'll help communities to share this dream, and I'm willing to take them through the implementation stage and even match them up with doctors who are eager to serve. I'd create a matchmaking service, empowering physicians and communities to create healthcare of, by, and for the people on a larger scale.

Passaro: Let's talk about pharmaceutical companies. What's their role?

Wible: They make it possible for doctors to move fast. It's much easier for doctors on the assembly line to write a prescription and escape than to spend an hour with a patient.

My first disillusionment with the medical profession had to do with the pharmaceutical industry: In 1993, while

I was in residency, I saw that estrogen was being prescribed indiscriminately to menopausal women without informed consent. The most commonly prescribed estrogen, Premarin, was the top-selling drug in the U.S. at the time. We doctors were supposed to tout estrogen's benefits: it's heart healthy, good for the bones, and stops those annoying hot flashes. That was the party line, and patients believed us. But there's nothing in the world you can say only positive things about. Even broccoli causes flatulence. [Laughs.]

I read everything I could find in the medical library on menopause, and I saw the dark side of my profession: the corruption and influence of money and corporate propaganda on physicians. I became knowledgeable about the history of estrogen, other cultures' approaches to menopause, and natural treatments for it. I started giving talks to community groups to educate women about estrogen and the treatment options for menopause.

Doctoring, at its core, is about human relationships. In medical school they teach you to be distant and professional, but that's to protect *you*. They try to make you this objective, emotionless scientist. But patients are not cars that need their mufflers changed.

My suspicions about estrogen were confirmed by a study the National Institutes of Health [NIH] launched in 1991. It was a fifteen-year clinical trial on the effects of hormone therapy on healthy menopausal women. A portion of the study was stopped early, in 2002, because of higher-than-expected incidence of breast cancer, heart attacks, strokes, and blood clots in participants who were taking estrogen plus progestin. The study also found twice the rate of dementia in women over sixty-five who were taking estrogen and progestin — and we'd been telling people it was good for the brain!

In 2002 the NIH added estrogen to its list of known human carcinogens. Currently the only approved indication for estrogen is moderate-to-severe hot flashes and vaginal drying, and then the lowest dose should be used for the shortest possible duration.

Passaro: How do you treat menopausal patients?

Wible: For hot flashes I recommend natural estrogens that occur in food, such as in flax seeds or straight soybeans, because they are safer than pharmaceutical estrogens. Sometimes hot flashes are exacerbated by anxiety. We are working women up into a frenzy about menopause. But it is a natural stage of life and not something to fear.

Passaro: Do you think the drug companies are causing the frenzy?

Wible: Direct-to-consumer TV ads can make people unnecessarily anxious. I don't own a television, so I'm always shocked when I go on vacation and turn on a hotel TV and see all the drug commercials. We're medicalizing normal body functions, so healthy people think there's something wrong with them. We're prescribing antidepressants to people who are not clinically depressed, because we want to suppress feelings of sadness. But it's normal to feel sad. The world can be a sad place. But I don't think taking a drug to suppress sadness is the right thing to do unless you're so dispirited you can't leave the house. Even then it's better to work through the sadness and get to the other side. I'm sitting here in this office now because I couldn't get out of bed for weeks. But I decided to really feel the pain, and it was enlightening. Six weeks of depression led to an epiphany and ultimately the creation of this beautiful clinic.

A lot of patients complain of fatigue, but when we do all the tests, everything is normal. So I take the time to ask them, "What's your passion in life?" If somebody has had fatigue for years, and they've tried this and that drug, and none of them has worked, it's important to ask why they feel they are here. Once people discover their purpose, they have more energy and don't need pills to cope with despair.

I want my patients' passions listed on their charts. I want to open your medical record and read one or two snappy sentences about who you are. Because if that's not there, then the only thing I read is "endometrial cancer, carpal-tunnel syndrome, fibromyalgia, chronic fatigue, mother died when she was forty of breast cancer." I don't want to look at this person and simply think, *She's doomed.* I want to know what her passion is in life. Who is this person sitting in front of me?

Passaro: Why are pharmaceutical companies so focused on treating nonthreatening conditions — allergies, menopause, impotence?

Wible: They're interested in developing products they can sell to the largest number of people. Viagra was originally intended to treat hypertension, but when companies discovered the erection side effect, they knew they had something they could market more widely. They want to find drugs to treat social anxiety or menopause — something that a large percentage of the population might suffer from. If you have a rare condition, you're out of luck, because the pharmaceutical companies can't make enough money finding a drug that would cure you. If you have a disease that's common in Third World countries, like malaria, they're not going to help you, because there is not much money to be made from poor people. But if you need an erection in the United States, they can help you with that.

The idea of a magic pill teaches people that the answer is somewhere outside of them: if I just get the right medicine, I'll be fine. This disconnects patients from their natural healing capacities. People come to the doctor for care and end up with a prescription. Then the patient has to come back the next week because of the side effect from the pill. It's a vicious cycle of not meeting people's needs.

Passaro: Your transition from overworked, unhappy doctor to part-time physician who spends an hour with every patient sounds like a dream. It's hard to imagine every doctor doing what you've done.

Wible: All doctors deserve to be happy. Some are happy working in urgent care and seeing sixty patients a day. They

love the adrenaline rush. It all goes back to your intention. I'm just saying that any doctor who is creative and has a passion for the job could do what I'm doing.

Part of the problem is that doctors are not taught to be businesspeople. I don't know whether that's omitted on purpose in medical school or not, but it keeps them tied to large practices and the status quo. All it takes to run a community-designed ideal practice is self-confidence and basic arithmetic.

Passaro: Do you see fewer patients now than you did at the various clinics where you worked?

Wible: Yes. If I cannot take care of myself, I am worthless to my patients. I need to work a human schedule to do that.

Passaro: I've heard the argument that if every doctor did what you're doing, we'd have a doctor shortage.

Wible: That's not true, because we'd actually have fewer doctors going into administrative positions and pharmaceutical-company jobs or otherwise giving up medicine. We'd have more doctors practicing part time while parenting. Older doctors would not have to retire; they could work part time.

Patients often don't feel so clingy when they actually have a physician who cares. They don't call for every little ailment and are better able to take care of their own healthcare problems, because they better understand what's going on with their bodies.

Passaro: Would it be fair to say that not all doctors share your interest in connecting with patients?

Wible: Of course. Different specialties attract different personalities. Some doctors love the thrill of cracking open a chest and performing heroic surgeries, and thank God they want to do that. I think most primary-care physicians or OB-GYNs or pediatricians would prefer to do something like what I'm doing now, but they are not exposed to other models.

If you're truly in it for the money, you'll probably go into a specialty where you'll make three times what I do, but I think most people who become doctors have humanitarian intentions. Then something happens where they get hurt and become detached or abandon their dreams. It becomes hard for them to figure out what they want.

Sometimes the confusion starts in medical school. We don't treat medical students like human beings. Instead we use intimidation and relentless competition and turn them into nervous wrecks. I think students need one mentor or instructor who believes that it's OK to feel sad when a patient dies. It's OK to be human and be a doctor.

Passaro: You worked for an old-fashioned country doctor as part of your medical-school training. How did that experience shape your philosophy about being a family doctor?

Wible: I followed him around for a month and watched him interact with his patients. He cursed constantly and called the women "sugar" and the men "partner." He saw most patients in the clinic, but on occasion we jumped in his old beater pickup to make a house call. At first I was concerned that he and I might not have much in common, but after a month I'd fallen for him and his colorful world. In medical school I'd done a lot of rote memorization that had little relevance to practicing medicine. I learned from this old doc that patients crave physicians who are vibrant, entertaining, and, especially, authentic; who are willing to reveal themselves and not just be robots.

Doctoring, at its core, is about human relationships. In medical school they teach you to be distant and professional, but that's to protect *you*. They try to make you this objective, emotionless scientist. But patients are not cars that need their mufflers changed. They are people with feelings and jobs and children and marriages, and they need to talk about the real-life issues that might be at the root of their high blood pressure.

I believe that physicians are not just providers of care but also recipients. Dr. Dan Shapiro, speaking to physicians about their patients, says, "Vulnerability is the ticket of admission to human connection." We need to get rid of this idea of professional distance and let physicians be vulnerable. That's where the answers to our healthcare problems lie. Everything has to start there. ■

My Father's Torso

MICHAEL CHITWOOD

It first appears in the guest-bath mirror,
beheaded and one arm missing
due to the angle I have of him
getting ready for his appointment.

The doctor won't notice the white hairs
over the nipples like a hard frost
or the sag of the once-tight pecs.
The chart notes read, "Elderly white male."

The years' slow chisel doesn't flatter
as paid sculptors did their patrons
with the stone breastplates of gods.
His good heart reigned in my childhood

but this emperor's statue is all too real,
the bent back and the fleshy swing of triceps.
The young physician's pose is classic.
He listens serenely, safe in his ancient art.

CORRESPONDENCE

IN JAMIE PASSARO'S INTERVIEW "WHO Will Heal the Healers?" [November 2009] Pamela Wible elegantly expresses what is wrong, and what could be right, with our medical system. I have been a registered nurse for more than twenty-five years. Before I became an RN I was a certified nurse's assistant and worked for a physician with his own practice. He charged patients whatever they could afford, sometimes as little as a dollar, and also accepted trade. All his patients loved him, and no one ever sued him, because he took good care of them, was honest, and listened to their problems. This was in 1973, before the insurance and pharmaceutical companies had a stranglehold on physicians, a time when doctors were actually free to practice medicine.

Gina Phelps
Huntley, Illinois

I HAVE FOLLOWED DR. PAMELA Wible's work over the last few years and have been inspired by her. As a primary-care doctor, I know the struggles she describes. I will be taking my own leap away from treadmill-style medicine in the coming year, a decision that's been a long time coming.

Aldebra Schroll
Chico, California

PAMELA WIBLE'S VISION FOR PRACticing medicine is noble, idealistic, and dear. Eugene, Oregon, must be an enlightened community where patients take more responsibility for their health than they do in the America that I know. Maybe obesity is not an epidemic there. Perhaps everyone exercises regularly, eats a vegetarian diet, refrains from smoking and using recreational drugs, and avoids other risky behaviors.

Here in New Jersey my patients are not so conscientious. I wish that I, too, could center my medical practice on "delivering a human relationship," but when I see new patients, they have often been obese and diabetic for years. They already have damage to their eyes, their kidneys, and their hearts and other vital organs. Wible describes her wariness of technology and her preference for being "low tech," but when patients have diseases like diabetes, laboratory technologies are an essential aspect of care.

I believe there are few doctors who wouldn't want to get off the merry-go-round of what Wible calls "assembly-line medicine," but most of us do not live in that golden city on the hill. We are forced to deal with the wreckage of our patients' poor life choices, and with a broken health-care system that continues to exert rationing and arbitrariness on our medical decisions. Just like Wible, we strive to be true to ourselves, to our ideals, and to our patients in an imperfect world.

Harry L. Chaikin
Brigantine, New Jersey

Pamela Wible responds:

Like my colleagues, I'm challenged to remain present for patients in dire and desperate circumstances. Most new patients to my office have seen multiple physicians but are still looking for a doctor they can "connect with." On reviewing their medical records, I find their prior physicians to be competent. They did everything right.

I, too, could just follow guidelines, place patients on textbook treatment regimens, order quarterly laboratory tests, and remain professionally distant to protect myself from their sad lives. And at the end of the day I'd receive a gold star as a top physician delivering quality care. If I played the game and submitted my data set to the right government agency, I'd even be awarded a "pay-for-performance" bonus.

The real epidemic in America is not diabetes or obesity, but the despair, hopelessness, and cynicism that feeds both patients' self-destructive behaviors and physicians' resistance to creating new ways to practice medicine. If we want our patients to stop abusing themselves with alcohol, tobacco, and food, maybe we should stop abusing ourselves by scheduling unmanageable numbers of patients per day, submitting to unfunded administrative trivia, and signing unfair contracts with third parties that destabilize our medical practices.

Innovative physicians across the country are leaving production-driven medicine and developing successful relationship-driven models. Let's help each other recapture our sacred covenant with patients.

READING POE BALLANTINE'S ESSAY "They Dream by the River" [November 2009], I marveled once again at how many Americans are unable to pay for medical care.

I've lived in British Columbia most of my life. In the early fifties my dad got polio and was in the hospital for two years. My mom had plenty to struggle with, but the cost of his care was not an issue, because we had provincial hospital insurance.

Twenty-five years later my second son was born premature. I'd been helicoptered to a large hospital, and he was in the intensive-care nursery for six weeks. The doctors and nurses were top notch. Our total costs were about three hundred dollars.

That son had many visits to specialists over the years, including two major surgical procedures — all at little or no cost to us. My husband was so impressed with the care our son received that he decided, in midlife, to become a nurse. After fifteen years he now works in palliative care. His patients have access to free drugs, home care, and a team of professionals to help them die at home, if that is their wish.

As part of his work my husband helps people negotiate our far-from-perfect medical system and determine what treat-

If you're thinking about writing us a letter, give in to the temptation. We love getting mail. (Of course, we reserve the right to edit.) Write to Correspondence, The Sun, *107 North Roberson Street, Chapel Hill, NC 27516. E-mail: letters@thesunmagazine.org. Fax: (919) 932-3101.*