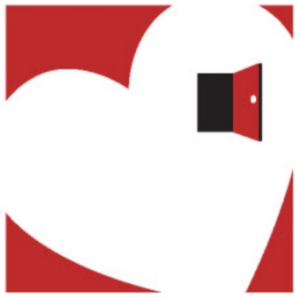

Handbook on Living Longer and Better

Healthcare that is not too hot, not too cold.

Tom Sloan, M.D.

January 1, 2017

Periodically I refresh your annual exam handout and now it has morphed into this longer guide.

In the past, everyone went to Marcus Welby and old Doc Welby just told them what to do. “Good health” has been made more complicated and along with that we are increasingly causing more harm than good – this must be set right.

Please put this write-up somewhere to read every word, as it will save a few lives, make others *much* better and almost all will be rewarded with at least simpler, safer and more satisfying health.

My Best,

Tom Sloan, M.D.

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THE POSTER-MAN

True story: I recently read of the gazillionaire who died young after getting short of breath while working out. He left young children, just as his own father did, dying when he was young. This is all I know and *that*, only to the extent some reporter got it right.

The story of someone bright dying unexpectedly is often not only predictable but avoidable. Our fictional man dies too young. Prosperous and intelligent, he had just had the executive physical through work. No doubt, he blew in tubes for no good reason, as well as having his "testosterone" checked and undergoing some cancer screenings that cause more harm than good – not a surprise when the goal of the enterprise doing the physical was to *appear* to be thorough.

The entrepreneur doctor knew little of good screening science so readily accepted our hard-charging, bright patient's explanation of how he was different than his dad who died early, "Dad, after all, was stressed at work, did not eat right and hardly ever exercised." The fact that such things almost never account for early sudden death did not get in the way of wishful thinking.

At home, our guy ate fish, worked out and gulped a bunch of supplements his reading had commended to him.

I regularly see smart people, trying to get it right, seeming to do a lot of the "right" things, get it wrong, perhaps assisted by *me* or other physicians.

Let's do our best. Let's enjoy modest confidence that we can do better. We will try to form accurate conclusions from accurate information.

EXECUTIVE SUMMARY

REASONABLE GOAL: LIVE TO AT LEAST NINETY IF IT IS ENJOYABLE.

- "First, do no harm." We must keep healthcare from hurting you and pursue only the right care for the right amount of time and energy.

- We can often find ways to keep you from getting killed or hurt by the most common problem: heart attack and stroke. *Since my first job in medicine, stroke death rate is down 77%, heart disease 67% – Wow!*

- We need to better understand which cancer screenings and treatments are useful and which can cause harm. *Over that same span of my career, cancer death rate is down a respectable 18%.*

- So many lifestyle choices and habits have been touted that we do well to choose the winners and learn to ignore those with lesser prospects of doing any good.

THINGS ARE THE SAME, JUST DIFFERENT

- Decades of health system upheaval and our evolving understanding find us facing "sudden changes". It is my job to articulate orthodox medical positions and yours to act in your best interest. This write-up seeks to untangle some confusion, move both of us to shared understanding and you to "informed decision-making".

- My hope is to see healthcare be a *smaller* part of your life but for you to get a "better deal" through skillful choices you make.

- Too much doctoring as well as non-doctor "hassle-factors" have caused a bit of chaos. Let's skip past the headaches and move forward to get the great benefits.

WHY SO MUCH TO READ?

If we are to thrive we must take advantage of the terrific advances in healthcare while remediating a serious deterioration in *delivery*. The day is gone that you can just "trust the system".

Back in the day, you *could* trust the process and you still can, but *only* if you are savvy. Except for insiders, few *are* savvy – the goal of your reading is to help you be more like an insider.

To some degree, we can simply "purchase" good accounting and lawyering without understanding much about them – just leave it to the professionals. I wish we could simply *purchase* trustworthy medical care but today, even Buffet and Gates need to understand the contents of this guide or risk having a good life harmed.

Those of you who prefer to be told what to do will need to move a bit toward learning new things and developing a little healthy discernment, lest your time, energy and emotions be abused or more importantly, to avoid being *physically* harmed by a system that is losing some of its emphasis on putting patients first.

Those who naturally lean skeptical or are a bit overconfident may do great in avoiding the downsides of healthcare but will also need to inch closer to the middle and learn some things or risk missing out on great science progress that might mean decades of longer *and* better life.

This was hard for me to write as it is healthy criticism of my own industry, my life's work and of me personally. The trick is to learn some new things but do not let it make you cynical, pessimistic nor avoidant. Plan to emerge with a confident attitude about a complex, changed system that you will navigate well in spite of new realities. Do this and you get the "square-deal" that healthcare should be.

KNOWING THE BEAST

Choosing well is not hard, just complicated by the self-interests of government, lawyers, insurance and doctors (including me) which are *different* than hospital, pharmacy and drug company self-interests.

As you read, begin to weave the various topics into a single picture that will have you skillfully tending to your well-being and longevity on *your* terms. This will take you more toward that "inside" understanding of healthcare and find you choosing "better for you".

It is beyond the scope of what I do for a living to suggest what another guy's philosophy or world view might best be, but it is absolutely in my realm to suggest that the viewpoint of each of us will *most* determine our overall sense of well-being and help or hurt us when we choose to pursue or decline various healthcare ideas. When health disappointment comes, our own sense of self is often the best tool in the tool chest.

While this handout is more an articulation of nuts and bolts, a description of how the sausage is made, your own development of beliefs, attitudes, methods and momentum are huge – work it. Be sure to compliment that good outlook with accurate ideas. There is nothing worse than having a great attitude that is paired with information that causes a bad outcome.

Between your best mindset and the contents you are reading, I am hoping for better, maybe fewer, choices that secure for you the good-value benefits while avoiding the too-often-of-late harms that have crept into healthcare. Let's get going.

BLAME WHERE BLAME IS DUE

It might surprise you that I intend to dispense with the usual targets of doctor and patient irritation and focus on the real problem which, I think I can persuade you, is ***doctors*** and ***patients***.

If you think about it a moment, that is pretty cool because you control half of that and I will do my best to help you "control" that other half – doctors, including me.

First, let's enjoy the fun of bashing the softer targets rather than doctors and patients, as there is some real meat on those bones too. BUT, it is our job together to mostly understand them, accept their unchanging reality and work around them.

KILL ALL THE LAWYERS

Let's don't.

I will lose some good patients if we kill all the lawyers. It is true that malpractice raises costs A LOT, not because I pay ten thousand and the obstetrician one hundred thousand a year for insurance, but because we order *zillions* of dollars of tests and even treatments, hoping we will not be blamed for things.

Unfortunately, such things do not cost just time and money. For example, one lawyered-up test might show a shadow that results in a biopsy that causes an infection that requires surgery, or worse. Perhaps *no* test would have been better?

You face the challenge of it falling to *your* discernment and preference to decide whether you think the proposed test or treatment is appropriate or just your doctor "lawyering-up".

I would love to tell you I don't do such things, but I am trying to stick to the truth.

KILL THE GOVERNMENT, AND THE INSURERS, WHILE YOU ARE AT IT

Big shock: Dr. Sloan thinks government is making healthcare worse and insurance companies want to make a profit.

Glad we got that one out of the way, but just like defensive medicine, this will not change. Doctors and patients must work well around it.

I cannot fix either one, so we simply jump through government hoops and go around insurance restraints. Your job is to accept the terms of your insurance or change your policy if you should. We do not like them, but long ago I made myself, my staff and our patients (you) a lot happier by deciding we will do whatever it takes to meet government and insurance requirements because we should. For my part we have moved on; mostly we don't complain and we virtually always get whatever is called for.

GOODNESS, DON'T KILL THE HOSPITALS

Over the years I have wanted to as the interests of doctors and hospitals began diverging around 1986. The agendas of the for-profit hospitals are obvious and the agendas of the not-for-profit hospitals not much different, as executive bonus structures can conflict with patients' best interests. These conflicts can be anything from understaffing to community screening that will attract patients for medical procedures that may do more harm than good. Don't believe that "National Bursitis Screening Day" is a good idea for you because a hospital sponsors it, nor because the local doctors are helping out.

Understand that hospitals want you to do well but they keep a sharp eye for ideas more in their interests than yours. Their reimbursement is under pressure and they have some realities and self-interests that can bring them in conflict with you.

EMERGENCY CARE

I think if you are dying, the emergency room next door is very good and the nearest emergency room is best if it is serious. However, if you are after-hours sick but not dying and should not wait until I am in the office, then the 24/7/365 Memorial Hermann Emergency Room (phone number 281-719-3333), back of The Woodlands, *across f*rom Wal-Mart, 9950 Woodlands Parkway, is the best in the region. Why?

That location has excellent lab, x-ray, and CT facilities. They see you *much* faster than the hospital emergency room and the doctors there have more time so do better work than they can in all the busy emergency rooms in America. This gives you faster, better answers. **No matter where you live, it is worth it to drive past others to go there.**

I like the fact that, unlike freestanding emergency rooms, hospital affiliated emergency rooms are generally better funded and the physicians are subject to medical staff discipline. As we talk physician self-interested behavior in later sections, it can matter that at this facility the doctor's reimbursement is not tied

to what tests they run. My observation is they go for the right answer, get you in and out and do it very well.

To summarize, in the greater Houston area, we have ample, excellent hospitals to choose from. I will endorse zero of them as exempt from having self-interests that often conflict with mine and yours but again, it is the job of doctors and patients to work around that and I think we are fortunate to have great options.

AH, PHARMACIES

Some do better than others and all face a lot of pressure from huge volume and low-profit margins, as well as other things.

In our experience, you might do well to consider Randall's, Sam's, HEB or Kroger as possibly more efficient. Also, if your insurance has three-month mail-in for long term prescriptions, this can make your life much easier, *if you order in time*.

There are many variables when it comes to keeping your prescriptions filled and it takes effort on your part as well as ours. The back pages of this handbook contain good pharmacy tips I hope you will read.

WHAT ABOUT THE DOCTORS?

Remember, the goal is best health outcome for you with the appropriate amount of time, emotion, self-discipline and money to reasonably match your well-informed preference.

Understanding doctors will help you do that. We will start with me and move to those I refer to and those I don't.

There are lots of conflicts of interest in medicine so I have tried to keep my own operation simple and transparent. My only source of income from medicine is ultimately, professional fees.

Lab and EKG are billed at rates some insurances have historically paid in hopes you might get some reimbursement. Though small discounts are given when lab and EKG are not done, we have to adjust the professional fee component upward

as the totality of my bill simply reflects time, overhead, decision-making and management.

I have no relationships of a business or financial nature with hospitals, pharmacies, drug companies or other doctors, nor do I own or invest in any testing facilities or anything else medically related.

My last effort to try to remove the money-factor from our relationship is to cheerfully limit the total collected in any one year for any who prefer this arrangement. I strive to limit lab and office visits as much as I can and still do good work.

I want to run a great office, take excellent care of you, stay affordable, make a living for my staff and myself and move on to being about the business of working with you for your best health.

A word about my staff: They are educated, experienced and have been quietly helping you and me do our best for a long time – they are also very nice. The machine runs most smoothly when we all accord them the friendliness and respect they earn each day.

I appreciate how so many of you are so pleasant to deal with and give us the benefit of any doubt – you are helping other patients, the team and certainly yourself – thanks.

WHAT ABOUT DOCTORS I REFER YOU TO?

I do my best *not* to refer to docs I worry are doing tests or procedures for money, but there can be some of that, even with careful selection by me. This often occurs even more when *you* choose the doctor.

Besides simple human greed, there are other dynamics afoot. The biggest problem is almost all specialists must be on almost all insurances and they have no control over inappropriately low fees. (If the expensive specialist is not on the insurances, the rest of us have a hard time referring to them.)

To try to find a way to be appropriately compensated, a lot of games get played.

Some own testing equipment they refer to or do procedures too frequently. The Sloan standard in picking consultants is that they must be good doctors and must not do *invasive* procedures that are not called for – these two are deal-killers. Beyond that the bar of personalities and financial games is, of necessity, sometimes a bit lower than I would like and even non-invasive tests that are not needed can lead to your harm so, read on.

I tend to refer liberally because, remember, I am a self-defense lawyer. The first decision for you to make is whether *you* think seeing the next doctor is appropriate. Seeing the consultant *can* lead to more harm than good.

When you *do* go, be in charge of what happens. If I send you to a non-allergist and they propose allergy treatment – don't. Instead, pursue the best allergist on the planet if you should. Ditto for sleep, pain injections, etc. Understand what you are going for and what the special expertise of that doctor is and stick to the script, not doing tests or treatment till you understand them.

Almost every day I encounter medical mischief wherein a test that perhaps did not need to be done shows something that needs SOMETHING and sometimes the outcome is terrible. I want you to develop a much savvier understanding of how to avoid this bad outcome.

Please know this holds true even when working with world-class, name-brand institutions and doctors – I know of no corner of medicine that lacks perverse incentives.

It is past time we practice economy (not financial) in tests, procedures and treatments. Medical ideas should not pass your smell test easily and if you have doubts, they should be resolved *before* you act – remember I said the problem is doctors *and* patients – you are stuck with the consequences so the responsibility really falls to you, even if you do not want it. If you have doubts, come see me and I will give you a very frank opinion.

An excellent way to discuss a test, procedure or treatment you are not sure of is to ask me, "What would *you* do if it were you?" My answer will be bluntly honest

and serve as a starting point – best for you may be different and that is as it should be. My answer will include my reasoning which may help you.

For example, if you ask and I tell you I would only get the CT scan that I am advising for you if my symptoms worsened or were not well in four weeks, you might realize Dr. Sloan is being very defensive about a "too-small" likelihood of serious complication by delay and you might not have the test. Conversely, how you feel or your common sense might reasonably help you decide that even a small chance of delay tells you that you think you should, "Do it now." Most things are seldom black and white. Asking what I would do if it were me and why, might help you choose best for you.

Bottom line: like me, my colleagues are making a living and the terrain is tough for everyone. I think you do well if you set the bar at "they had better be talented and *never* do an invasive procedure that is uncalled for". You also need to decide for yourself about tests and treatments.

Some doctors I refer to are friends of a sort but I decided a long time ago that I will not and do not refer to specialists because they are friends – it makes your life better and mine a lot simpler.

HOW ABOUT IF I JUST FIND MYSELF A DOCTOR?

Some of the doctors on my referral list I learned about from some of you, so who knows? Having said that, I see more unusual or questionable things and complications, etc. from the visits to the specialists my patients find (because a friend or homework got them there) than the *many* visits to doctors on the list.

One way of seeing doctors I do not refer to is when an emergency admission gets the consultant on call. The doctor might do a great job and warm your heart but when the dust settles, we should consider whether you might be best served by a doctor "we" think is better. If there are questions about a consultant while *in* the hospital, you and I should collaborate on whether it is best to keep the momentum or change consultants.

Some of the docs I refer you to could give you either an unpleasant bedside-manner experience or less than perfect outcomes. There are many good physicians not on the list, so don't ever let me talk you out of pursuing such; be careful and let me know who you think is good. They may not make it onto my list but it is updated continually and you might just improve it.

I mentioned it before, but let me point out that the many, often new, independent emergency rooms that have popped up everywhere are often owned by the doctors who see you. I feel I am seeing over-testing that leads to *more* problems and mediocre treatment choices at these facilities so I believe the hospital-backed facilities are better.

I dislike lesser, doc-in-the-box outfits because they frequently make poor choices. I believe it can be best to go to a good place or wait until I am back instead of going to a grocery store for a non-doctor to see you.

Your life will be easiest if you schedule your illnesses or injuries for when I am in the office (just kidding) but if it should not wait until I am back, choosing the appropriate emergency room for quality care is my advice.

Remember, it is my policy to see you the same day if you call by 10 A.M. and your problem is appropriate to the office. We take this pledge seriously – know that calling by 10 A.M. will get you an appointment that day except the rare times I am out or your problem should be addressed elsewhere, like the emergency room. Knowing this might help if you have a night or weekend decision to make as to whether to be seen right away or wait until I am back. My answering service can confirm I am in the office the next day.

THAT INFORMATION MIGHT JUST KILL YOU

Whether me, those I refer to, those I don't, hospital, job or church screening fairs – just because something medical exists, doesn't make your participation a good idea. This is very true of "information" as well. Just because someone says it, doesn't make it so.

Over the years, I have read hundreds of journals each year. I study, think and practice full time. I periodically get something wrong in spite of the process. Begin to understand how hard it is for even your diligent Google-research to get it right.

If that hasn't gotten us tangled enough, decades of consumer interest in health information have brought out the good-looking TV docs who talk nonsense, the homely ones who often get things right (but no one hears them), and the nuts, flakes and silly who constantly yip-yap. Example:

From Wikipedia:

> *Popular Science and the New Yorker have expressed criticism of Dr.Oz for his non-scientific advice. These criticisms include questioning if he is "doing more harm than good". In an article in Slate, a medical researcher said that Oz's work bordered on quackery. The James Randi Educational Foundation has given Oz its Pegasus Award for Refusal to Face Reality at least three times.*

I turn to Wikipedia, Slate and Randi, not as great sources but to articulate what I hear the very few and brief times I have tuned in on Oz. It is breathtaking how commonly even smart people might find the frequent nonsense he spouts to be credible – we just *have* to be more clever than that, for the sake of both of us.

Oddly, I do find Wikipedia to be the best tool available to you at home for medical information – usually better than prestigious medical school websites and newsletters, WEB MD, and even your careful review of original articles out of context.

A long discussion of why Wikipedia and not Mayo Clinic is not possible but the short version is, Wikipedia is up-to-date, often written and edited better than the best encyclopedia while enjoying brevity and clarity. The big problem is that it can be 100% wrong at any given moment, though it seldom is.

I detect in the writing of great institutions or Web MD either self-serving bias or paternalistic over-simplification that might incorrectly assume you cannot understand complexity.

A GREAT BUZZ PHRASE

Recently, the medical literature has begun to talk as if we discovered the concept of "shared decision-making". No matter that we are late to the party; the idea is certainly the best idea.

I am thankful you and I have adequate time to do a proper history and physical and for me to give the best advice I can. I am also grateful my patients are *quite* bright.

Now, let me saddle you with a big responsibility: There *is* no "shared decision making" because, in the end, only ***you*** will decide on any suggested tests or treatments. I think that is just as it should be, but routinely I might see even smart people bring a lot of preconceived, faulty notions to the table. I sleep *great* at night when I see someone understand a subject well and, based on ***informed personal preference***, choose something different than I/we might suggest. I toss and turn when it seems foolish or based on false notions that our conversation may not have untangled.

Bottom line: when you and I have conversations, relax – I do not care one bit if you decide whether to "take the pill" or "get the test" or not (except that I like you and don't want you to be harmed needlessly).

I *do* care that you fully understand the subject *before* you decide on things that can kill or maim you so you may detect some energy on my part to gain confidence that you have comprehended what I think is accurate information. Feel calm, knowing I consider it the best in "shared decision making" when you absorb such and decide to do whatever you think is in your best interest.

Some of your biggest challenges will come in *correctly*

deciding *not* to do some things "we" might suggest.

EXHIBIT A OF DR. SLOAN LAWYERING-UP

This section provides examples of what has been said. I hope reading it will increase your skill level in pursuit of best health.

Let's say you come to see me for a headache. Most headaches are innocent and answers you give to questions I ask serve to sort out most headaches without tests. Rarely, a headache is life or death, *today*. Give me certain answers to certain questions and I will tell you that you need to drop what you are doing and go now to get a CT scan and spinal tap that might affect whether you are still breathing tomorrow.

Thankfully, most people with headaches are okay and any who *do* need testing will get normal results. The smaller number of those with "the problem" benefit. I will speak clearly and you will know from my tone if I believe it would be "foolish" to not have testing (or as other cases may be, to not take the pill, get the treadmill, see the gastroenterologist, etc.). Such "life and death" situations are pretty easily defined.

Back up though and realize conversation matters. You were having a bad day and now a bad headache and when I asked if it was the worst headache of your life, in a moment of feeling badly you inaccurately said it was the worst of your life, upping the likelihood of unnecessary testing. Next, the spinal tap worsens your headache for days, till a second procedure is performed to fix the "spinal tap leak".

Less life-and-death *today* is your headache that "could be a brain tumor". (Hopefully you are following that this conversation applies to abdominal pain, high cholesterol, Vitamin D testing, colonoscopy, pill taking and all things medical.) Again, good answers to good questions sort out whether pursuing the brain tumor idea makes sense. Unlike the life-or-death-today problem where the right path is clear, physicians like me often do the brain-tumor-thing "wrong".

Good science demonstrates that without certain types of neurological findings, a tumor is very unlikely. Further thought also suggests "preemptive" discovery of the rare exception to this has little likelihood of adding benefit.

Such information then, might call for exercising restraint in ordering an MRI. However, years of doctors being blamed in the course of making their best-effort-judgment-calls has warped most physicians as it probably has cops, teachers, attorneys – the list is endless. There is no value in wallowing in the woes of a silly and litigious society so let's return to how it would be wise to exercise restraint in ordering that headache MRI.

Well, your doctor hears the story, examines you and suggests a diagnosis that does not call for an MRI. He senses your concern is *not* allayed by his suggestion that an MRI is not needed at present. Now his concern for blame and self-preservation rises.

The fact is, it is not *impossible* for you to have a tumor and he is sensing that he is not being called on to practice good medicine, but to "guarantee" he is correct, "*right now*", instead of offering a best path. It is *impossible* to guarantee anything nor will best medical practice always provide the "correct" answer on first pass.

So, this leads to the doctor ordering the MRI which doesn't show a tumor but does show a "funny shadow" which calls for two more tests on two separate days as suggested by the radiologist, who has his own self-defense to think about as he over-reads the study. He also happens to profit from the additional tests.

Unfortunately, the tests do not quite resolve what the shadow is. There is a logic stream that might suggest, "The highest probability is that this is innocent and if not, the risky biopsy offers little prospect that will affect the outcome." However, such a thought is often totally over-ridden by the foregone conclusion of steps to avoid being blamed for delayed action. The biopsy *will* be advised.

It is a shadow in *your* head so you consent to the biopsy and, after you get over the bad infection, you do not suffer a catastrophic stroke nor cognitive impairment this time so we are all eventually relieved. When the pathologist says, "benign", we were lucky because he did not say, "Benign but specimen is inadequate. Suggest re-biopsy . . ."

Return to the fact that a good history and physical suggested **no further testing was needed** but a doctor and patient managed to proceed to a cascade of

medical mischief. Whether self-defense, patient anxiety, doctor or hospital self-interest, good intentions or ignorance, be aware the primary reason I have re-written this handout is due to alarm over seeing this type of problem **EVERY, SINGLE, DAY**. It does not matter that sometimes it is my making, sometimes patient's, sometimes other doctors'; the point is the frequency of such has increased. We must collaborate to reduce, if not end, such.

I will work on my part but some tips on what you can do:

- **Understand the value of a good history and physical exam**. The very first day of medical school they told me that if I sat and asked you questions, before I get out of the chair to examine you, I should already have a good idea of what is wrong. After the physical exam, which occasionally helps, we *really* hope I know or will send you to someone else who will know, *because* the proper role of testing is *mostly* to *confirm* what is suspected, not to go fishing and cause problems because the doctor did not know.

  It is true that testing occasionally finds us "lucking into" a diagnosis but much more often untargeted testing leads to the "headache-MRI" problems and complications. All the great technology tools developed since that first day of medical school have not changed this principle but have enormously increased our false claims, findings and harm.

- Since you understand the *value* of the history and physical there are several things you can do. First, come ready to be an "expert witness". You are the **only person on earth** qualified to tell the story of how you feel – do it well or it will be done poorly. Practice. Write it down. Bring your notes.

  Next, stick to what you are an expert at – the story. It is a big job and hard to do well. I call my mechanic and I do a world-expert job in telling him, "My car won't start". Next, I play the fool with something I know nothing about and tell him, "It needs a new battery". My mechanic is a smart-alec so he puts a new battery in, calls me to discuss the bill and tells me the car still won't start; then he asks if I would like him to do what he does well, which is figuring out what is wrong and fixing it.

There is nothing wrong with you wondering if it is “low potassium” or “it might be that new medicine” or “I had an uncle with the same symptoms and it was Kuchimanga Disease”. However, if you save those kinds of things till *after* you have expertly told what you are the only qualified person to tell and then allow me to do what I do, there is a reasonable chance you won’t be thinking potassium.

When you and I pursue the Kuchimanga idea first it is not just that we lose the limited time but worse, you don’t walk out with my best. Walking out only knowing what you did when you walked in is a poor outcome so practice, write, bring notes and make a home-run delivery of your expert testimony.

OK, TELL A GOOD STORY, WHAT ELSE DOC?

Become really good at getting me and your other doctors to speak clearly. First, you do a great job of telling the story, then allow us to ask some more, examine you some and then know it is our job to have a preliminary assessment we should be able to articulate to you. If we do not give you that, persist in asking for it and block the door till you get it: **History, physical, spoken assessment**.

For example, after a history and physical, maybe I say, “You have asthma, take this medicine and see me if it is worsening or you are not well in two weeks.”

Your job is to decide if that makes sense to you and if so, to go with it. If not, this is a great time to ask if it could be low potassium or Kuchimanga Disease.

You might ask whether a chest x-ray, lung specialist or some morphine are called for. I will do my job and say, “no” to the morphine. Then I will hope to do my job and go with the chest x-ray and/or pulmonologist if I was on the fence about them and sense your preference for these reasonable ideas. I might instead tell you why I am concerned that the risk of opening that can of worms would out-weigh any likely benefit of the chest x-ray or lung doctor.

I might think your sore elbow is caused by your golf swing, so I advise, “Take this pill, rest the elbow, use this brace and see this orthopedist.”

Remember that I am a self-defender, so if you are on your best game you squeeze out of me that the pill only helps symptoms, doesn't fix the problem (only time and rest do) and that you need a 12-step program to quit golf awhile. This news brings to your golf-addicted soul the idea that the brace *will* help as you ignore my advice and play anyway. The referral to the orthopedist was partly to increase the expertise brought to your case and partly to avoid my being blamed in the extreme unlikelihood it is something more dreadful than golf-swingitis.

Consider seriously that the pill could cause side effects without fixing you. The best advice of resting it, however long it takes, was somewhat under-emphasized.

Seeing the orthopedist may have benefits but it also increases the risk of unintended consequences. (Self-interested testing, procedures, costs and complications.)

It was a simple sore elbow but *before* you even mentioned it, you needed to have a practiced, skilled story to tell, then pause and let me do my job. You then have to skillfully decide whether what I said matches your common sense and personal preference. You need to do all that with an eye toward helping us not violate that principle, "First, do no harm."

WHAT? COULD YOU SUMMARIZE THAT?

Enjoy a good life using your common sense to tell doctors about things you should in a context that allows adequate time for you to give an expert account of the problem, for the doctor to finish the history and physical and then to give you a diagnosis and plan.

At this point, ask enough questions to decide what to do next, based on what was suggested, modulated by your informed view and consistent with your personal preferences – simple and elegant, when done well.

Be of good cheer as you are called on to wade through defensive and self-interested medical practices. Understand the landscape and persist in questioning enough to understand your best decision and defer action till this is so.

If this is hard work, I am sorry and I will help any way I can, but choosing to participate in bad-care-gone-wrong is ***harder work*.**

FINAL WORD

I hope you remain optimistic, content and confident that healthcare truly has never been better and we intend for you to enjoy those benefits, hoping for a good, long life.

I also hope I have explained some things that may help you conclude you might not participate in *everything* proposed to you. Such might be based on a well-informed assessment that includes your preference and understanding of any downside.

We are all fortunate to live in the best of times and I hope these thoughts might serve as a mild corrective if the ship is a bit off course. Think of healthcare as best when it provides some benefit but not perfection while not taking too much time, emotion, energy and money. You are better served by this than by our giving the false impression we can offer perfect or even nearly perfect benefit and, along the way to pursuing what cannot be had, we exact too big a toll.

DOCTOR, YOU ARE WEARING ME OUT

If you have read to here you have done well and the probability is high you will be rewarded in excess of your effort. Let's summarize:

- You are sophisticated in realizing you should only introduce medical questions you believe are "worth the risk" of our pursuing.
- You know it all starts with your expert-telling of the story and that your doctors should hear the story, examine you and articulate a likely diagnosis and course of action.
- You understand it is best for you to decide if the proposal makes sense to you, being careful to avoid harmful testing or treatment due to doctor lack of knowledge, doctor/patient anxiety, over-concern for self-defense or physician self-interest.

Before going over individual screening tests and immunizations, there remain worthy issues and examples that are a bit random.

MY FAMILY WANTS IT

I am glad families care for each other but when a husband "knows" his wife should or should not have a certain treatment – look out. It is the same when a caring family wants a certain test. In general, I often see patients and families, who are legitimately concerned with chest pain or whatever, underestimate the value of the history and physical and overestimate the value of a treadmill or CT scan and tremendously underestimate the harms caused by imprudent testing – *you* are more sophisticated than that.

It is terrific for family to expertly say, "I am concerned because he/she is tired, short-winded, mean, pale, etc." It is well-intentioned but unwise when that leads to family saying, "Maybe he should do this test or take this pill." That reminds me of the hard-charging doctor who insists to his lawyer that he is going to testify on his own behalf. It most likely won't end well.

Most family things come from either frustration or understandable anxiety, perhaps because you may have seen me or other doctors several times and are not doing better.

You guessed it; an excellent avenue for handling this is to sit down, write out a good account of the problem and, even though I may have failed to fix things so far, re-present the problem, briefly including any frustration or anxiety.

A DAY IN THE LIFE OF IMPERFECT DOCTORS

The following describes some shortcomings and how families can work skillfully when what we do comes up short. It also does a good job of illustrating how you and I work together, along with other doctors.

A patient recently saw me with new shortness of breath and tiredness on top of longstanding tiredness and not being in very good shape. His medications and history are not simple and visit time, even in my practice, is limited. First, a history and physical: I work to satisfy myself he is not in danger of immediate heart or

lung problems and do *not* note if he is pale. He had somewhat recent lab that was okay. I do not have a diagnosis so refer him to a specialist.

He sees another doctor and from that visit there is a correctly diagnosed blood loss anemia. A thorough GI work-up shows an upper gastrointestinal leak.

My history and physical failed to get an answer but the system worked fine, so far. He reasonably needed two units of blood and treatment for the leak.

Problem: over a couple of months he is given four more units of blood and five intravenous infusions of iron – he must still be leaking. The family believes they are being treated correctly and have no reason to think differently.

All the while, I know nothing of the extra transfusions and iron infusions. Often specialists no longer send reports in the chaos of modern care and when they do, they are frequently six pages of computer generated gibberish. I faithfully review all that come my way but it is worthwhile for you to know I regularly get *no* feedback and when I do, even after reviewing these nearly unreadable reports, I am often not able to connect the dots and conclude something is not going well.

When you are "out there" and things are not going well, let me suggest you assume I know nothing about it and do what this family did. Though I did not figure the problem out in the first place, they kept confidence and since he was not getting well, they came to see me.

When they came in his wife made the expert testimony statement, "Doctor, we are getting worn out by all these infusions and transfusions and he is not getting well." It perfectly articulated an unresolved medical problem, frustration and weariness. (Notice she did *not* propose what she thought was the next right step, thus avoiding wasted time or worse, ill-advised steps that might lead to complications.)

Thoughts on this: Even when I am not the one doing the work, if it is not going well, your problem is my problem. Do what this family did – make an appointment. Come ready to give a clear account of the problem and assume I know little or nothing of what has transpired, as I either *do* not know or the understanding I have may be incomplete. Your carefully crafted account will get

me pointed in the right direction and from there, history, physical, appropriate tests, treatments and specialists when needed.

We placed this man on oral iron he inexplicably had not been prescribed and further gastroenterology evaluation was conducted and found to be OK. A few days on the oral iron and he felt better than he had in months. A few weeks and his blood count was back to normal and stayed there.

Bottom line: consider it my job to help you gain satisfactory resolution to whatever problem, even if I come up short at times or other doctors are not getting it. Assume I am barely, if at all, aware of how things are going except to whatever extent you tell me. Never tire of working on giving your carefully rehearsed version of the story and keep confidence that sound principles of good history, physical, selected tests, treatments and specialists will almost always get things right, even with some failures along the way**. We have no approach better than this.**

The strength of you and me working together is that I know you well, I take more time than most to put thoughts together and I consider it my job to help you get a good answer. No question, there will be imperfection, but both of us remaining optimistic and staying focused on the main problem almost always works well.

Take seriously the notion that when families press for resolution or clarity, this is a great thing. When families press for the perhaps ill-advised test, treatment or non-treatment and things do not go well, it is not such a great thing.

While it may be the most natural thing to suggest car batteries to mechanics or tests and treatments to doctors, a family member permanently incontinent, disfigured, in pain or worse due to ill-advised medical mischief is not what any of us had in mind, so channeling concern into a disciplined account of what is wrong is my suggested path for finding good resolution together.

ANYTHING ELSE?

Yes. You understand history and physical matter most and take time to do well. If we limit the number of things addressed in a visit you have a better likelihood of

good answers. Annual exams allow more time for more issues. Briefer visits are for fewer. It falls to you to bring an organized agenda, in order of your priority, lest we stray. I too often spend most or all of a visit on a secondary issue only to have the major concern voiced on the way out the door – bad outcome.

There are two excellent ways to handle this:

1. Be in charge of the visit by making it clear to my staff and me what the *chief* reason is for the visit at the beginning and be sure we spend our limited time on that.
2. Some patients have a number of issues that might logically call for several, very frequent visits. I never tire of seeing you as it is all I do.

If you find a brief visit inadequately addresses what may be several problems, I suggest you make a second or third appointment as soon as we both can to continue pursuing good answers. This can be very natural and serve the useful purpose of having a day or two for you to regroup in articulating the issue.

I am never too busy to see you often but almost every hour of every day it is not possible in a brief visit to do justice to a complicated problem or do a good job addressing too many smaller problems. I am trying hard to provide adequate time to do things well but there is no substitute for taking the time, so if we need a second visit, please come back.

SO MANY VOICES

Besides Oz-like, crummy information out there, there are so many unqualified voices that the noise is becoming *visible*. This is America and doctors don't know everything *but* I am concerned that many patients find it too credible when the health fair people say, "You might have diabetes", "You are at risk for a stroke" or the vitamin guy says his product will do this or that. The nurse or P.A. said something different. Too many people saying too many things, including doctors who may not know, including me.

My advice is not paternalistic, but *practical*. My advice is to mostly stop reading and listening to almost everything and everyone medical. Many other subjects in

life are better to focus on than the over-emphasis on medical matters that has been out there for decades and has grown out of control.

Begin to view almost everything you read or hear as coming from people who are selling something, exaggerating from bias, ego or ignorance or talking about what they do not know for the sake of deadline, filler or advertising sales etc. Begin to correctly ignore almost everything and I cannot imagine how you would miss out on what matters**. I am certain far more harm than good has come from listening to and following what is out there.** Keep life simple.

If something written, televised or spoken nonetheless *does* make it onto your radar, before finalizing an idea, ask a doctor you have confidence in. Remember, Grandma did not focus on how insects that were fed more sugar had baby insects born with extra feet, yet Grandma did just fine.

LIKE WHAT?

One area that I am surprised is so easily accepted by Americans concerns supplements. Most folks are not aware that supplements are not regulated and many have bogus claims, known and sometimes dangerous impurity and little to no likelihood of doing anything useful.

I cannot make sense of putting a supplemental chemical in my body with the knowledge they often contain things *not* on the label and knowing that the chemical will be absorbed in my bloodstream where it might cause harm.

Prescription pharmaceuticals are overseen for quality and studied for safety and effectiveness before being allowed on the market. They are first calculated by smart science guys, not drug companies, to be of more benefit than harm, and those who prescribe or sell them are held highly accountable.

My personal standard is that it does not go into my body unless I know what it is, there is proof of benefit with small enough downside and that I think I *need* it – otherwise, “No”.

The days of easily believing all things medical need to be over. This goes for what any other doctor or I might tell you, what you read or hear and whether it

involves “natural” or “artificial” substances (a distinction with *no* credible meaning – cyanide is natural for my headache and Tylenol, artificial).

THIS IS SLIPPERY – GIVE ME SOME SOLID GROUND.

So far, most of us have probably gained at least *some* new insight into today’s healthcare. Many of us, perhaps a disturbing amount.

We are all different but, like you, I will die someday and tomorrow am subject to every kind of dreadful health possibility. I believe it is a useful exercise for me to tell you how I grapple with my own humanity but as an *insider.* You can adjust this read for how you are different than me.

I have average interest in my health, I am not anxious by nature, am approaching geezerhood and have my own world-view/philosophy that is, of course, uniquely different from yours.

I start by using my brain not my heart to work at accepting my inevitable death and being comfortable knowing that disappointing health lurks – it is right that you young guys enjoy your youth but even you do well to give death or a health problem a moment’s thought.

I think when we realize death and health disappointments are common, not special, we gain personal power over trying too hard to get the healthcare system to deliver what it cannot and perhaps avoid it harming us in improbable pursuits.

I try to eat and exercise well and not overdo other things, but know the science says this is no substitute for picking parents with good genes. I try to be philosophical about the limits of what my good habits can deliver and especially not rob myself of joy by not getting overly excited about my shortcomings in cultivating all those good habits.

I was relieved at the recent expert analysis that clearly articulated what this insider has known for decades (as have most doctors and many of you) and that is that most cancers are random bad-luck, not the result of our evil habits or neglect.

While this does not make bad habits a great idea, it does serve to remind us all to get cooler and more philosophical and tell all the voices that have crept into our heads, about how, “ice cream is going to give us colon cancer” or whatever to “**settle down**”.

We will all wind up tied for dead with Plato, Saint Thomas, George Washington and Great Grandpa. Whether young or old *does* matter, but our brains might help us see it is all not as significant as our feelings might say – a view that can be soothing if cultivated.

I personally participate in the screening tests that good science supports and am vigilant to not allow doctors or insurance companies to do tests on me that can lead to harm without science to support their value. I take the recommended vaccines, as insiders easily understand, when benefits greatly outweigh risks – nothing wrong with non-insiders being careful shoppers, but head-in-the-sand or ill-formed bias is not the dictionary definition of “careful”.

I take a small number of pills that deliver big bang for the effort. I take an occasional multi-vitamin because I don’t want to work at getting citrus but otherwise, no supplements.

I think the biggest irony observed in my professional life is the not-small numbers of smart folks who uncritically take a handful of probably tainted, probably worthless supplements they hope will do something. Meanwhile, the Internet or whatever has them unwilling to take the cholesterol pill that would probably deliver what they wish the supplements would. (Cholesterol pills are not appropriate for everyone, just a lot of folks, case by case.)

Like I hope you do, I give thanks for the many other skilled, dedicated specialty doctors out there. If I bleed in my head, have a car wreck or a bad appendix – maybe it is just my time to go, but I am glad these guys give me a last shot at sticking around if my crisis comes.

"ELECTIVE" MEANS "YOUR CHOICE"

Now, on a more *elective* basis, I am still glad the specialty doctors are there for the many benefits they might bless me with BUT, I am really careful. I start by prudently ignoring things, hoping they will go away as I avoid the risk of even mentioning it to a colleague. Your job is tougher because you have less idea of what is prudent avoidance but there is a BIG DEAL concept here. What you CAN do is prepare yourself for a "yes" answer from doctors.

Go see the doctor because "it hurts here", but *before* you go, recall what you have read about how defensive or self-interested doctors may advise more than is wise and a lot depends on *you*. If you project anxiety you are more likely to be over-tested or over-treated. If your doctor does a history and physical then voices reassurance, that is not the last chance to pursue the problem – my best advice is to tentatively trust that reassurance.

If you are a skeptic and your voice betrays doubt that a simple history and physical is adequate, you may be inviting the next bad idea.

It is unlikely that accepting, "Yes, this problem is okay for now, let's see how it goes," is going to lead to avoidable catastrophe – remember that most doctors are already self-defending against that – in your interest, of course. (Was that last phrase sarcasm or irony? I forget.)

If simple history and physical suggests nothing more is needed, that is a reason to rejoice, but not to check your brain at the door. If days and weeks later the problem is worse or unresolved, go back.

I doubt any doctor ever says, "It is nothing, final word." or "This will fix it and if not, I am out of ideas." Whether from concern over time, money or thinking the doctor is busy or wouldn't want a second chance**, I *very frequently* see patients not take advantage of one of the best tests or second opinions out there: the same, qualified doctor doing a *second* history and physical – go back!**

If you read this handout carefully, you will save so much time, money, mischief and complication that you will not feel disappointment over *legitimate* use of

more time and money to “get it right”, even if it takes multiple tries – go see the guy *again*.

I think your good reading of this material gives you a clear eye. Your brain knows medical things do not lend themselves to perfection every time on first pass so you respond to such with a quiet-but-firm expectation of resolution via revisits. You will rightfully expect me or other doctors to feel a similar sense of “Hey, let’s redouble our effort to get this right”. If you do not get that sense on re-visit, perhaps it *is* time for that second opinion. Be frank and ask.

I find it often is impossible to be certain that your problem couldn’t possibly be “such and such”. ***Remember doctors, hospitals and healthcare cannot deliver such guarantees and pressing to get what cannot be had, greatly increases harm compared to benefit.*** This is a good place for your own world-view/ philosophy to stand in the very real gap of our inability to resolve everything, today.

ENOUGH ABOUT ME, DOC; TELL ME MORE ABOUT YOU.

Okay, so I am happy for my sake that doctors might save me while I am dying and I prudently do the few tests and treatments I should while not going to doctors when I should not. Once there, I follow the principles already written – I give good information, persist until I receive clear advice and decide what to do based on my informed preference – we are back to “simple and elegant”, when done well.

The last part of the formula is I tend to my own view of things as I see fit. Whether you are the coldest rationalist, the most far-out of spiritualists or somewhere in between, incorporating the disappointing fact that we all die or might fall ill tomorrow into your philosophy will pay you back. Plant it today, water it tomorrow, someday add a little fertilizer, weed your patch and be ready – the day *does* come and your work now will not only reap better fruit on that day but it will also make you more comfortable ***now*** and *that* might **keep us from over-pursuing a matter and *spare you* from medical mischief**.

WHAT ABOUT ELECTIVE SURGERY?

Some of you have rushed to have surgery on something that hurt or was cosmetic or imperfect and were rewarded with a quick, clean, excellent outcome. It fit your bias for action and if it had not worked out as well, you were prepared to be a good sport. Sounds good, was good, is good.

I am much slower for such myself. The good I may be hoping for may happen perfectly or only partially and may only "work" for a season until I am back to square one.

Anesthesia death is rare. Bad, even permanent effects from anesthesia are not as rare. Infections, blood clots, unanticipated pain, a worsening of the problem and other complications – they happen. The procedure might not work, I might hurt more, be less attractive or I might see more poorly.

Emergency (not elective) surgery is amazing in that I almost never perceive it as a bad idea and even when outcomes are poor, they are usually better than the alternative.

I set my personal bar for *elective* surgery mostly at "no", and then when prolonged desperation leads me to give it a try, I bring low expectations and a readiness to be a good sport if the results are not great.

Some elective surgeries are more likely to help than others but even then, waiting until the price of a complication or ineffectiveness would be "worth it" makes sense.

I can't address every surgery nor do justice to the details but read through these "top of my head" thoughts to maybe up your game in considering whether to do something "elective".

The usual things about doctor bias, good intentions and self-interests apply. I will not go in any order and comments are my bias, not a full, fair rendering of all facts. With work, you can and should do better.

Sinus Surgery – Maybe home-run for life, more often brief home-run for a few years of help. Then, similar to before. Sometimes, a total bust – no value. It can drive me crazy to see it done before optimal medical efforts are tried – too common, so ask.

Tonsils out– Rarely called for**.**

E*ar tubes* – In adults, looks about right to me; can help in tough situations.

Eye Lasik – Less perfect outcomes than many realize, sometimes pesky worsening, rare risk of disaster.

Cataract & lens implants – Awesome when finally needed – getting "early" to make vision more fun or shed some glasses – gotta hope no complication.

Thyroid Biopsies – Usually "fine needle aspiration" because we see a nodule on some other test. (One of those "medical mischief" things I talk about.) This is getting to be a huge problem, in that we "invented" this "new way" of approaching incidentally found, common, usually-benign thyroid nodules.

In Korea they actually *screened* for nodules on purpose and did what we do when we find them by accident: biopsy. They did not reduce the very rare *death* from thyroid cancer but increased the diagnoses and "need" for treatment a whopping seventeen-fold!

This is terrible medical mischief and I do not know how to get out of it as all doctors, including me, are reduced to being self-defense lawyers. Probably the right answer is we should go back to the standard of care twenty years ago before we invented all these thyroid aspirations without science backing but, at times, no one seems in charge of our ship. Years ago we looked at each nodule case by case and rarely evaluated one with biopsy.

A way you *can* avoid entanglement is to stop doing church and lifeline screening tests and tell doctors you don't want that carotid ultrasound test if you don't need it. The former are second rate screens you and I have already considered and done with better technology or not done because the risk of mischief outweighs benefit. The carotid ultrasounds from other doctors are seldom called

for and can get you into the thyroid nodule business – we also see them on unnecessary head, neck and chest CT, MRI and ultrasound.

Heart stents – My observation has been that cardiologists I refer to virtually never stent when not called for. Nationwide this is a problem and I absolutely *do* see it with doctors I do not refer to.

Heart cath – Has never been a problem in my circle but lately, with reimbursement down, I feel like I perceive a few more being advised. We have so many good ways to often *not* cath that I think making an appointment to brainstorm such with me would be smart if an elective heart cath is advised.

Atrial Fibrillation – I am learning to hate this more common problem because the way we treat it versus how we treated your grandpa is very different, for very *real* reasons. This is one of those situations where a few folks enjoy importantly better outcomes but most folks probably get entangled in ten-fold more complicated treatment than gramps, often for little and even *no* difference in outcomes.

This does not mean we are doing it *wrong* but rather it is complex and, I think, has no one-size-fits-all answer.

If you have A-Fib, it might be worthwhile to make an appointment and pick my brain about your treatment to be sure "we" are all matching your personal preference, given the imperfection of proceeding to ablation, electrical conversion, drugs to stay out of A-Fib, drugs to slow heart down and blood thinners.

Cosmetic Surgery – I see a few home-runs, plenty of cosmetically not-that-great outcomes and more medical complications than one might think. Seems to me the less ambitious projects are the ones that work the best.

Weight Loss Surgery – I am a fan of gastric sleeve and in some cases even gastric bypass and mostly a critic of the other procedures like lap band. Probably we do too *few* weight loss surgeries as so much health outcome can be positively affected. I never advise *anyone* to have the surgery as I think it is a specific,

personal choice, but our talking about why and when it might be a great *strategic* health move for you can be a good conversation.

Hernias – Seldom cause severe trouble left alone and beyond surgical risk carry a chance of problems you did not have before surgery.

C-Sections – Probably overdone but also one of the great tools to have spared Mom and child. I know of no way to get it right except choosing a trustworthy obstetrician.

Hysterectomies – Maybe overdone in the past, maybe better now with newer, clever approaches to the most common cause, which is excess bleeding from fibroids that will usually quit with menopause.

Hemorrhoids – Specialty, colorectal surgeons can do a lot of good in the office and avoid operating room surgery which can be painful. Understand, hemorrhoids can come and go, get worse, then get better. Avoiding procedures is probably best unless having pain too long.

Bladder/Pelvic – These procedures can be so tricky or ineffective that I may be ready to claim they are best done only if the problem is quite bad and only at "specialty centers" so that if and when they do not work or cause problems, we all feel we had no choice but to try, and that we chose the right place and surgeon.

Prostate – We do less actual cutting surgery for benign prostate problems than in the past because of pills, lasers, microwave, etc. There is value in men understanding, from age 40 and onward, some amount of getting up at night to urinate, frequency, weak stream, urgency, dribbling, etc. is as normal as a deterioration in basketball skills and it is worthwhile to read more under Prostate Cancer Screening to understand the vexing problem we have of pursuing benign symptoms and not easily avoiding getting entangled in "over diagnosis" of prostate cancer.

Total Hips and Knees – Seems about right out there. Most people seem to wait, then have the surgery and get good benefit. Absolutely it matters who the

surgeon is and the effort you make at rehab is usually important in affecting your long-term satisfaction.

Knee Scopes and Rooster shots – Two surprise findings of late have been that most knee scopes for torn cartilage do more harm than good if due to age, arthritis, associated with obesity and not a specific injury. I have heard plenty say it seemed to help and I still think youngish, thin people with injury may benefit.

Surprising to me and plenty who get rooster shots, they appear to do no more good than a placebo.

Foot Surgery – My office manager of twenty-five years ago who worked with orthopedists and then with a foot doctor, famously stated, "No foot surgery works." While not entirely true, I think it serves well to especially emphasize, "Do not do the contemplated procedure until the problem is so bad that if you wind up worse, you will feel very good about the surgeon you chose and the fact you simply had no other choice."

All other Orthopedic Surgery – It can be amazing how an x-ray or MRI might show horrific damage or tears and yet time and physical therapy may deliver a perfect result. Often the physical therapy has huge prospects, but some patients do not do the P.T. home exercises – not so bad if the surgery goes okay – potential for giant, unnecessary disappointment if surgery goes wrong. Most backs and necks that hurt do not need surgery.

Veins – If for cosmetics, contemplate a fair, not great result and I think modest satisfaction awaits. For large varicose veins that ache, I think good relief from discomfort and modest cosmetic gains are common enough. It is probably best to work with surgeons who do little else.

YOUR ANNUAL WITH ME AND THE COMPANY PHYSICAL

I work hard to do an annual physical that sticks to good science. There is no test that the experts in screening science suggest be done that I do not include and I try to keep the rest to what is needed for me to get re-acquainted with the details

unique to you, avoiding things like automatic treadmills, total body scans, blowing into tubes, etc. that go against best consensus opinion of what should be done.

Our once a year time together hopefully heads off problems and also makes things go much more smoothly when you have “something big” come up at two in the morning or two in the afternoon.

You can tell I hate it when our good intentions cause problems that are not problems and even my annual exam can raise false issues concerning your sugar, blood pressure, EKG etc.

Plenty of good science suggests some of what we do at physicals is “too much” and, when you get entangled in my falsely raising a concern, I tend to agree. Having said that, I have done my best to make your once a year checkup reflect best possible balance of harm and good and believe it works well to your advantage.

If the doctor doing the company physical is prepared to write prescriptions, see you when sick, be your doctor and provide 24/7/365 coverage and you prefer that, that seems reasonable to me and I can bow out.

Most don’t. I believe such physicals with a doctor who is not your regular doctor, would best *not* be done. My objection is it interferes with our doctor/patient relationship and almost always includes ill-advised testing that our best experts say causes more harm than good.

If you have such a physical, (I know sometimes they are required) feel free to bring lab and EKG to your physical with me and save a few dollars. At our physical, as I am working on knowing your situation the best I can to provide ongoing care, if you would like, let’s discuss details of what has been done and why I might advise you to politely refuse some parts in the future. I think those details would be time well spent in avoiding the complications or excess procedures that sometimes come from such physicals.

GETTING OLDER

Not for sissies. Let's claim most do fine no matter what till age 60 and from 60-90, a lot depends on what we do going forward. A discussion on what to do now makes sense.

60-90, get weight bearing exercise, especially upper body, which helps balance. Get a little thinner, stay active, treat blood pressure, cholesterol and diabetes well while avoiding tobacco. Avoid too many medical enterprises but choose the things that make sense.

Given that alcohol can increase your prospects for dementia, imbalance, cancer and a number of other undesirables, age 60 and older becomes an especially best time to reconsider how much alcohol you intend to drink.

The deal with alcohol is that plenty of us very honestly come by a genetic affinity for the stuff that makes denial, bargaining, rationalizing, etc. commonplace.

Best trick is to probably get away from being defensive with your know-nothing internist or meddling friends and family and retreat to yourself for a strategy session. The strategy question goes something like: "Having avoided alcohol problems thus far, do I want to let this tendency that I did not ask for (liking more than average alcohol) *probably* steal from me in these upcoming, high-risk years?

I see a lot of smart folks decide to change a lifetime habit and quit entirely as they conclude they are no good at having just a little – *most* will be rewarded.

MORE OLD-GUY AND OLD-GAL STUFF

Wrap your head around the fact you will die sometime and that you might be infirm before that. Recall, such work on your part not only makes it easier on you but, more importantly, it will help you not over-seek remedies for things perhaps better taken in stride, keeping safe from some medical mischief.

If you are over 60, I think there is a pretty good chance the rest of your life will be blessed by a 55 minute video and 5 minute read – both easy Internet searches.

The video is “Frontline: Being Mortal” and the read is “How Doctors Die” – Ken Murray, M.D.

These are uplifting, not discouraging and may provide some vision and comfort in your own skin that I cannot articulate as well.

Each generation seems to be improving, probably from good pills and because we are staying more active and engaged, sometimes eating better and prolonging the onset of our becoming “frail elderly”. If you did not exercise before age 60, maybe no big deal. After 60, not exercising will almost surely curse you.

I agree with everything you have read about staying in the game but still see plenty who have some difficulty finding a game to stay in. Employment usually works, though slowing down is good. Some do okay just doing “stuff” but most seem to need productivity or some other sense of purpose. Good luck, I think it is an individual deal.

As you move to frail, get feisty. Find a way to stay in your home, hire caretakers if need be – do not let your car keys get away too frivolously. It is possible that heavy-handed key-taking is a well-intended-but-misguided over-reaction in some instances. If it comes up and you do not agree, I am happy to give you and concerned family my opinion.

Do get that hearing aid before you alienate your last friend or family, before you get discounted as an old guy and before decreased hearing contributes to you developing dementia.

The above efforts are making inroads against dementia and, also, cancer care has never been better. Though we cannot beat every cancer, I think our biggest unsolved dilemma is those crummy years of “frail elderly” or dementia. Best I can say is shape up, treat 60-90 differently and, unlike when younger, the odds that your good or bad work will matter go *way* up.

CANCER

After heart disease and stroke, cancer is the next most common way we die. Given the plunging incidence of arterial disease, especially in those well evaluated

and treated, I believe cancer may even become *the* most common way many of us will die.

Nothing fits what is said in this write-up more than cancer. Screening tests, good treatments, bad treatments, bad tests, making decisions that reflect your values rather than "our" values, world-view/philosophy – cancer will challenge your talents, intellect and emotion most every way.

The facts are:

- Cancer prevention is worthwhile.
- Most cancers are not preventable.

- Cancer screening saves a few lives but also causes plenty of harm.
- Maybe not everyone should participate in every cancer screen.

- Cancer treatment can be curative.
- Cancer treatment can be futile from the start, cruel and harmful.

Doctors often carry the best of motivations, integrity and professionalism. When doctors are self-serving in cancer treatment, it is worse than bank robbery, worse than an honest hit on the head and occasionally maybe worse than a murder done quickly. We all do well to polish our best game on this one.

Of first importance is to realize that just because we all hate cancer does not mean we have useful prevention, avoidance, screening, early detection or treatment. We all *know* this but cancer is so spooky we often make the bad worse by falling into bad screening ideas, over-optimistic notions of preventive efforts, too many tests and treatments. (Another irony is how often we might opt for cancer treatments with little likelihood or even *no* prospect of it working while avoiding artery treatments that often *do* work to successfully prevent the more common heart attack and stroke.)

Studies clearly show we are also reluctant to call palliative care and then hospice early enough to make the best of our bad situation.

The best time to learn "enough" about cancer is *before* you or yours have it, so studying a few principles *now* is a good idea. The back of this guide has an extended section on cancer that is perfect to read soon.

QUACKERY

This is really just a word or a meaningless accusation till you understand what it is so you can judge for yourself and decide if you want to participate. I believe people with M.D. behind their name engage in it some – I wish that did not include me but, who knows.

It has the following characteristics: The Quack will state or imply he has specialized knowledge or skills the others do not understand or are jealous of or perhaps his critics are in league with BIG PHARMA or whatever. He is usually preying on areas where conventional medicine is imperfect – maybe cancer, low back pain or "brain-fog" (a quack label, invented to appeal).

Maybe he invents other diseases (adrenal fatigue, yeast overgrowth, etc.) or maybe he just intimates he understands, where others don't, how to *best* treat real conditions like low thyroid (he just gives too-high, harmful doses), obesity (he is eager with pills – if that worked, wouldn't we all be thin?). With menopause, this untrained guy naturally knows more than gynecologists. After all, what would a mere "baby doctor" who is well trained and spends his whole career in it know about women's health? "Bio identical" and "compounding" are just too special and sophisticated for most of us "rube" doctors to understand. (Ok, *that* was clearly sarcasm.)

Not a big shock that the wellness center quack is pretty costly – it stands to reason that such distinguished, secret talent should be recognized and compensated accordingly. (even more sarcasm)

It is not really any of my business if anyone in America elects to be a part of such. Maybe placebo, maybe they *do* know something. After all, the clairvoyant who makes 400 predictions on New Year's Eve gets a few right every now and then or, "even a blind hog occasionally roots out an acorn".

Know that it is my view that more and more doctors seem to be so discouraged or disenchanted with medical practice that it seems quackery-for-profit is on the rise. I think some of these doctors are cynical, some ignorant and some just unscientifically believe their own baloney. Regardless, at least try not to be harmed beyond your time and pocketbook if you choose such.

Another trend of concern is not quackery – just imprudent. I am referring to when Sloan, the internist, is suddenly talking to you about vein treatment, cosmetic treatment, certain vitamins or supplements for sale or whatever. Recall previous advice to seek the best qualified practitioner for various things, whether allergy, sleep, pain, cosmetic, "wellness" or whatever.

OTHER DOCTORS, PART II

I am painting what I perceive as an accurate picture of health care having become a bit chaotic. I hope what you and I do together is nearly chaos-free. I hope when I send you for tests and treatments, the various facilities are ever-improving at decreasing the chaos but when you encounter such, my advice is to just expect it a bit and cheerfully work through it – no better choice.

Once we involve another doctor, the experience might be terrific, well-organized and well-executed. Some tips for when that is not the case:

First, if you cannot get a timely appointment, secure an appointment for whenever you can and tell them how you would like to be on the list to be called on short notice to fill in late cancellation problems they *often* have. *Sell* them on how great your prospects are to drop everything and be there on a moment's notice.

If your common sense says you *still* should be seen sooner, call and ask my staff to ask me if we can call to try for sooner. Appreciate though, that I have limited currency to spend on such requests and when I feel urgency is called for I usually have already made that call so I might reply, "three months from now is soon enough if things don't change".

I recommend against your agreeing to see the physician's assistant instead of the doctor. Texas law requires your permission before the substitution and if you encounter such, I suggest a polite but firm, "No". This might mean it takes longer to be seen – take longer.

When things do not seem to be going smoothly with the specialist, it is almost always best to call their office, make the next available appointment and be *very* prepared to clearly describe what is not going well. I advise trying as hard as you can to shrug off rude or ineffective staff and even take a stab at working through personality differences with a specialist. My reasoning is, they were "our" first choice, they have momentum in your case, they might get better over time and, given that health care too often has such a problem these days, there is no assurance our next choice will be better. Nonetheless, if it is not working, you are not improving and you have tried with re-visits, changing to another doctor certainly *can* make sense.

We cannot afford low expectations on medical outcomes but keeping expectations low on personalities, efficiency, etc. is a good idea, especially for pharmacies and insurance companies. For things you and I might think should happen in 20 minutes, figure an hour instead and be less disappointed.

Do not expect phone calls to other offices to be effective – make another appointment and *go* when something medical needs to be untangled. Administrative? If a phone call does not work, your smiling face at the reception desk probably will. Be nice, so that at least one party in the relationship will be.

SECOND OPINION

If you are not getting a good outcome from a specialist or from me, it may be time for a second opinion. When I am not getting you a good answer, I am pleased when you seek another viewpoint. I hate it however, when the second opinion is a poor choice, so do good homework.

One piece of advice: if you walk in and say, "I think I might have multiple sclerosis but Dr. Smith thinks I am crazy . . ." you are not getting a second opinion. The guy will waste most of your time together wading through those distractions.

If your problem merits your time, effort and energy for a second opinion, it is important you **give that disciplined, expert account of the facts of what you have experienced and when**.

Do not *hide* information but avoid telling the second opinion what you or other doctors think and avoid talking about test results – remember, it is *your* history-telling and *his* history-taking and physical exam that are most likely to lead to a right answer and it is up to *you* to make your expert testimony the focus; then let him do his work. It *is* reasonable, at the end, to then bring up multiple sclerosis if you still wonder.

GENERALITIES ABOUT SCREENING TESTS

When the medical profession does things right, very few screening tests pass the rigorous scientific requirements needed to advise the screening test be done. The principles are that the disease should be common and bad enough to be worth screening for, the treatment good enough to avoid the bad outcome, that it will be worth your time, effort and money and the harm of the screening and treatments small enough to be "worth it".

I think the most useful screening by far is screening for your risk for heart attack and stroke by looking at your age, sex, family, cholesterol, blood sugar, tobacco history, blood pressure and a C-reactive protein blood test. Depending on the results of that, maybe nothing more is needed in you, or you may need more tests or treatment to avoid this most common cause of death and health disappointment. We *should* be concerned you might have such if you have a pulse because it is so common and our ability to avoid such arterial problems is excellent. (Recall our collective failure with the poster-man? He had a head full of wrong ideas and did a lot of medical things, yet we dropped the most obvious ball.)

By contrast, we have *some* good screening tests for various cancers *but,* given that only a small percentage of people will die of any *one* of these cancers, the science supporting a screening test for say, colon cancer, must demonstrate excellent characteristics.

We are plagued with causing a lot of harm from well-intentioned screening efforts that got ahead of the science. You might grow to appreciate this as we examine the various screening tests. Even very smart people do not easily understand some of how screening causes harm. Among those who do, there is still room for personal preference so I hope, before your next serum rhubarb test, you develop an informed view and the test being done represents what *you* think best.

Things are different enough that I no longer feel comfortable simply providing a table that says do this or that. Instead, each section regarding a test, immunization, etc. will endeavor to explain enough for you to choose what you think best. It is worthwhile for men to read about mammograms and women about the prostate as principles apply that carry over to other subjects.

In my practice, some patients want "everything" and I think that is great when everything done has a basis in fact of doing more good than harm. If you trend this direction, no need to change but keep a sharp eye to *not* do things more likely to harm than help. Usually, if you prefer "everything" you are a person of high standards, so carry on and demand good supporting information – not even "the Mayo Clinic said so" or "MD Anderson said so" is good enough. Primary facts and broader consensus opinion form the basis for best information. (I am hoping that by now you really do understand even our very own, beloved and highly-respected-by-me MD Anderson, is subject to the bias, self-interests and defensive posturing that plagues us *all*.)

The guy at the other end of the spectrum wants almost nothing. Believe it or not, I can semi-support these guys as well. In my opinion, if one has an extreme preference to be left alone, maybe simplest would be to tell me that and ask me what about your case, if anything, I might see as foolhardy in not doing.

It hurts nothing for me to explain the small but real risk of perhaps not taking certain health measures or the colossal foolishness of not treating something like the 300 cholesterol dad gave a guy before Pop died of his heart attack at age 48.

FINALLY, THE NUTS AND BOLTS

I am choosing to cover *more* topics than previous handouts but the huge number of "guidelines" out there cannot all be articulated in any practical way so feel free to ask about topics not covered.

Guidelines are tough because they come from best available science as interpreted by a smoke filled room full of experts who emerge and tell you and me how we should do it. Though some of these "consensus opinions" are better than others, I generally respect this process as representing the best of my profession. Sometimes, I have to judge which of two guidelines that do not fully agree is "best".

Notice, I am trying to give enough information about vaccines, tests and habits for you to choose and shape your own personal approach.

BREAST CANCER SCREENING

Linda is not sure what to think about breast cancer screening. She is a thoughtful reader and sees smart doctors saying different things – one making a case for no screening and another for screening every year.

Most of us know someone who has had breast cancer so this conversation can push a lot of buttons. I am your doctor and good doctors try to provide accurate information – not doing so might be referred to as "bad doctoring". So, put on your steel-toed boots and do not let honest information easily hurt our good relationship if my well-intentioned efforts inadvertently step on toes – we can do this.

I BELIEVE MAMMOGRAPHY SAVES LIVES AND HAS VALUE.

Not only is this written in bold, but you *know* I will self-defend with advice that women should get a yearly screening mammogram starting at age 40 and ending when less than 10 remaining years of life is expected. What Dr. Sloan does to self-defend is not very good guidance, nor is the same advice we gave 20 years ago best for today.

If we approach screening mammograms as a personal choice you decide on, instead of "one size fits all", perhaps you will be better served. Some will make a case that whatever *informed* choice you make about breast cancer screening will be the *right* choice for *you*. The better you understand the subject, the more I think they could be correct. Hang in and wade through this information that may help you decide.

COMPLICATED CONVERSATION

The following is from the Harding center for Risk Literacy. Before reading, skip to the data box below and let me comment: Notice this shows one in a thousand mammogram participants will not die from breast cancer that would have, though the number of the thousand who die of *any* type cancer is *no* different. Treatment *causing* a cancer death *might* account for this but so could the shortcomings of 10-year, instead of 40-year data – 40-year data might show more benefit. It is reasonable to observe that whatever the benefit, it will be huge for those who benefit, however statistically unlikely it might be in any one person.

The 5 women per 1000 per decade who are diagnosed and treated (though they never would have been harmed) merits a bit more consideration. This number does not also account for the four in 1000 who are diagnosed early, treated and unfortunately die from breast cancer.

We might say they experienced benefit because they found out earlier, giving them time to make arrangements or for other reasons. However, some might say the early detection cost them whatever carefree time (probably years) they would have had before detected a different way, with the same outcome. In some ways this might be considered "harmful".

I can see how some would say *no one* benefited because the number of *total* cancer deaths was the same or, one in a thousand benefited with 100 harmed a bit and five were harmed *a lot* because they were treated "unnecessarily". I can see how some would say it was more like nine (5+4) were harmed *a lot*. What matters is for *you* to develop your own informed preference and act accordingly – it is hard to imagine how you would choose wrong.

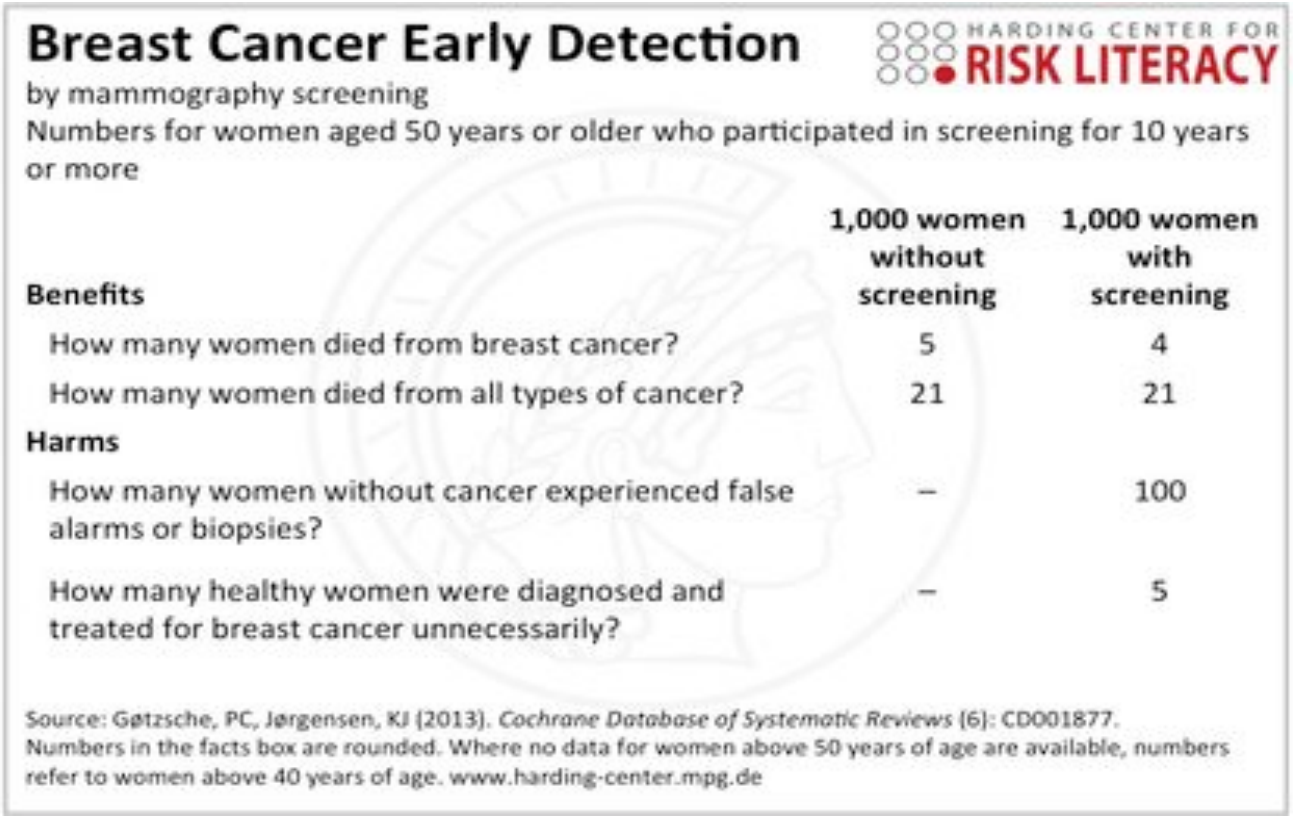
RISKS AND BENEFITS OF MAMMOGRAM SCREENING –

EXACT WORDS FROM THE HARDING CENTER FOR RISK LITERACY

“Screening for breast cancer with mammography is offered to older women at no cost by health insurance in many countries. Mammography is an X-ray examination of the human breast and aims to increase the chance of recovery by detecting existing tumors as early as possible. But what is the actual benefit of mammography screening and how frequent are potential harms? And would participating in the screening be advisable for you?

Medical questions often have no clear-cut answers. For this reason, transparent information is crucial – as is the courage to make informed decisions oneself. To help you weigh the pros and cons of mammography screening, we have prepared a fact box with neutral and easy-to-understand information about its harms and benefits.

The numbers refer to 1,000 women over 50 years of age* who participated in the screening for 10 years or more (screening group), compared to 1,000 women of the same age who did not participate in the screening during the same time period (control group).



The fact box shows that mammography screening reduced the number of deaths through breast cancer from 5 to 4 in 1,000 women. This effect had no influence on all-cancer mortality: the number of women who died of any cancer was the same in both groups.

100 of 1,000 women in the screening group had at least one suspicious screening result within the 10 years, though it later proved to be a false alarm. Some of these women had to live with this uncertainty for months and had to go through further diagnostic testing until the all-clear could be given.

Mammography screening also detects so-called "indolent" (slowly growing or less aggressive) tumors, which would never develop into a life-threatening disease. But because their development cannot be predicted, about 5 of 1,000 women in the screening group unnecessarily had their breast completely or partially removed.

Unfortunately, few reliable studies to date have investigated mammography screening. The numbers in our fact box are taken from a systematic review of

these studies and hence offer the best evidence available. Nevertheless, the numbers should not be seen as definitive but instead as roughly conveying the extent of possible benefits and harms."

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Probably your eyes are now glazed over but the bottom line is I cannot imagine how whatever informed choice you make about mammography that includes your personal preference would be a "wrong" choice.

PHYSICIAN AND SELF BREAST EXAM

In spite of our recommending self breast exam for years, best guidelines based on evidence do *not* recommend you do this. Calling our attention to lumps discovered still seems appropriate to me.

Breast exam by the physician who orders your mammogram or by any of your physicians if you forego mammogram is still advised. If you want me to do your exam just ask, as it is not a routine part of my internal medicine annual exam.

PROSTATE CANCER SCREENING

If you would like a PSA test, just ask and it will be done – this is available to be drawn every day that we are open and can be requested by you at any time.

The US Preventive Services Taskforce recommends ***against*** prostate specific antigen (PSA) based screening for prostate cancer. Though they are very smart regarding the science of screening, not everyone agrees with this recommendation and therefore, the choice is entirely yours.

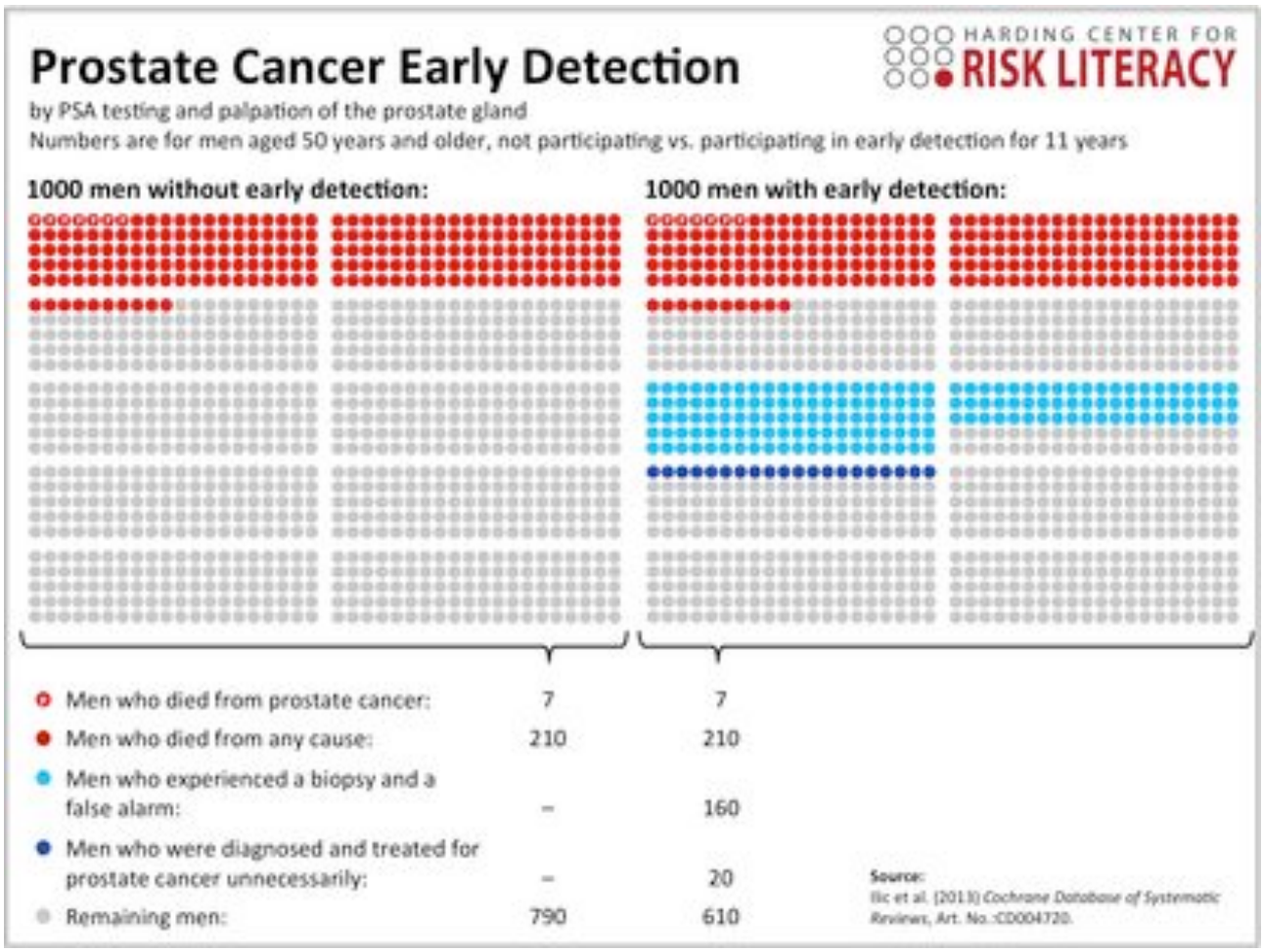
Below are 2 brief presentations from opposite viewpoints. Harding basically says, "No" and the urologists make only a soft case for your consideration if age 55-69.

I do not believe the fact I have personally never had a PSA and am unwilling to, means that you should necessarily choose the same. Each of us has different values, some wanting to avoid mischief, others wanting to avoid most every possible eventuality, even if the likelihood of benefit is small and the cost potentially high.

RISKS AND BENEFITS OF PROSTATE CANCER SCREENING

(FROM THE HARDING CENTER FOR RISK LITERACY)

"We have prepared a fact box with transparent, up-to-date information about the risks and benefits of prostate-specific antigen (PSA) testing, which include the overall and prostate cancer specific mortality rates for groups that participate in PSA screening and those that do not.
It also specifies which number of PSA screening participants will receive a positive test result even though they do not have prostate cancer (called a false positive result), and how many healthy men were treated unnecessarily due to these false positive results.



THE GREAT PROSTATE MISTAKE (STILL HARDING)

In a New York Times article, published in March 2010, Richard Ablin, the scientist who discovered PSA in 1970, argues against routine screening as "a profit-driven public health disaster", which in fact is hardly more effective than a coin toss. In the United States, a recommendation against prostate screening caused an outcry, even though the benefit of these screenings was called into question through objective data."

THE AMERICAN UROLOGY ASSOCIATION GUIDELINES

These guidelines are from the American Urological Association. Historically, they had been VERY aggressive in their advice for PSA screening but the science has caused them to re-tool and I think these guidelines are a decent balance for the more negative-toned Harding presentation.

Notice only statement 3 (box below) would lend much support to PSA screening and critics might point out that additional useful information might be the Harding point that ALL CAUSE mortality is not reduced in men who undergo PSA testing. Approximately 74% of deaths due to prostate cancer occur over age 74, an age at which *no one* recommends screening.

Guideline Statement 1: The Panel recommends against PSA screening in men under age 40 years.

Guideline Statement 2: The Panel does not recommend routine screening in men between ages 40 to 54 years at average risk.

- For men younger than age 55 years at higher risk (e.g. positive family history or African American race), decisions regarding prostate cancer screening should be individualized.

Guideline Statement 3: For men ages 55 to 69 years the Panel recognizes that the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment. For this reason, the Panel strongly recommends shared decision-making for men age 55 to 69 years that are considering PSA screening, and proceeding based on a man's values and preferences.

BACK TO SLOAN-TALK

Though enthusiasm for PSA has waned, it remains that you are a bright guy and I think these brief presentations adequately inform your decision – I don't think you go wrong, whichever choice reflects your personal approach.

Perhaps you best decide whether to have the test done in the common sense fashion that if your personal preference is to be willing to undergo treatment that may have even impressive, permanent side effects for a small chance of receiving benefit, then the test might make good sense for you.

If, on the other hand, you are prone to not wanting to take on the risk and harm of treatment unless a substantial likelihood of benefit is to be had, then perhaps

this test does not meet those criteria and perhaps you would be better served by not having the test.

Feel free to discuss this further with me or, if you know you want the test, just ask me or any member of my staff and it will be done.

PROSTATE EXAM

There are valid reasons you might prefer to tell me you do not want a routine, annual rectal exam. If you do, I can mark your chart accordingly. Of course we would still do the exam when symptoms call for it.

The reason you might logically opt-out is that the major organizations do not urge this exam as a screen for colorectal cancer nor prostate cancer. My career, anecdotal experience has been to have NEVER detected a colorectal cancer with this exam, though a small number were there to be detected and my exam failed, generally because of flat cancers or the insensitivity of the exam. Thankfully, colonoscopy did NOT fail in these cases. I have detected a few prostate cancers but, just as with PSA testing, the benefit of such "early" detection has not been validated, though harm has.

Because it has been a part of your physical in the past, I am happy to continue to do the exam if you prefer. Should you prefer we forego this exam, let me know and I will mark your chart accordingly.

THE DILEMMA OF BENIGN PROSTATIC HYPERPLASIA (BPH)

Starting around age 40 and worsening with each decade, the normal growth/enlargement of the prostate, which completely encircles the urethra as it empties the bladder to urinate, begins to cause all kinds of NORMAL symptoms. These include frequency, weaker stream, urgency, dribbling after urinating, getting out of bed at night to urinate, hesitancy, etc. While annoying, so is that humiliating deterioration in basketball skills with each decade and probably most men are well served to the extent accepting these symptoms as a normal-enough part of aging is deemed acceptable to them.

If the symptoms become alarming or too annoying, we have remedies that start with simple pills, move on to complicated pills or the urologist can sometimes do in-office procedures that have words like "laser" or "microwave" attached. More

rarely, the old, not-small, surgical procedure of "trans-urethral resection of the prostate" or TURP remains the best choice – the urologist, in the operating room, goes through the penis and "reams out" the inside of the large prostate.

The dilemma in having these normal-enough symptoms revisits the problem we have with screening PSA. If you choose PSA anyway, no dilemma; if you have symptoms, we do a PSA. If you studied PSA and decided you do not want to risk getting a cancer diagnosis that might not benefit but harm you, look at this edited-by-me info from the good source called "Up To Date" that talks about PSA with these symptoms (which IS different than SCREENING an asymptomatic guy) and note their reluctance to say it should be done and the usual, doctor self-defending reluctance to NOT do it:

"Serum prostate specific antigen — Prostate cancer can cause obstructive symptoms, although the presence of symptoms is not predictive of prostate cancer!!!! Measurements of serum PSA may (they say "may", not "should") be used as a screening test for prostate cancer in these men with BPH, preferably in men between the ages of 50 to 69 years (the only years ANYONE sort of recommends PSA) and before therapy for BPH is discussed. The following points should be kept in mind when serum PSA determinations are ordered and the results interpreted:

●The specificity of the serum PSA assay is lower in men with obstructive symptoms than in asymptomatic men (meaning, if you have symptoms of large prostate, PSA is likely to be higher because of the benign condition but can lead to the cascade that can get a biopsy and perhaps a cancer diagnosis without clear, net benefit.) In men with prostate enlargement, the serum PSA value and prostate volume have a log-linear relationship but there are conflicting data on its utility for predicting development of Lower Urinary Tract Symptoms. Older men tend to have a steeper rate of increase in prostate volume with increasing serum PSA concentrations.

●High values occur in men with prostatic diseases other than cancer, including BPH.

●Some men with prostatic cancer have serum PSA concentrations of 4.0 ng/mL (a widely used cut-off value) or less. (I bolded the next sentence not because of

importance but because, after all of what is said above, I find it vexing.)

A combination of digital rectal examination and serum PSA determination provides the most acceptable means for excluding prostate cancer."

OK. That very last sentence is the dilemma. While it is a perfectly true sentence, it has us back to pursuing prostate cancer because of extremely common symptoms, with cancer probably NO more likely because of those symptoms--I have never seen data to suggest the presence of cancer would increase these already near-universal symptoms.

MY dilemma is that the untenable blame-game stuff leaves me vulnerable if I do NOT do a test (PSA) that my best judgment says stands to do you more harm than good but ethically, I am unwilling to do the test without your INFORMED consent – consent I, personally, would NOT give to any doctor for symptoms I judge to be far more likely Benign Prostatic Hyperplasia.

YOUR decision will be to tell me whether to proceed with PSA or NOT, before I CAN prescribe pills. If my pills are ineffective or if this entire "uncertainty" leaves you with any doubts, I suggest you go see a urologist where I anticipate NO subtlety nor hesitation; they can be expected to do a PSA and proceed accordingly – that could easily be best and most comfortable for you and I am delighted to simply observe.

This "problem" is not unlike the one I described regarding our "standard of care" in doing so many more thyroid aspirations with data showing harms but not persuasive to show benefit--we do pretty well in medicine but there are times when it really does seem no grown-ups are in charge and "standard of care" lacks good data but the blame game assures 99.9% of doctors, including me, are going to self-defend. The best I can do is try to describe when that is the case, tell you what I might do if it were me and leave you to decide based on YOUR preference, which can very logically be different than mine.

Those who tell me of BPH symptoms will probably be asked to read these sections before we begin to discuss PSA, pills or urologists any further.

COLON CANCER SCREENING

Colon cancer screening is also not straightforward. I will discuss those of us at average risk. Those who have a mother, father, sibling or child with colon cancer should be screened more often than what I say. (We do not strictly consider more distant relatives.) Those with prior polyps need to work with the gastroenterologist for the correct interval.

It takes 10 years, maybe longer, on average, to develop a polyp that *might* turn to cancer, spread and cause death. (Most polyps do not turn to cancer but almost all colon cancers come from polyps.) Gastroenterologists might recommend screening more often than guidelines do, so you do well to ask why, if that is the case. Our journals discuss and hint at the notion we may be doing more colonoscopy than is appropriate. In looking for an explanation, round up the usual suspects.

I am only going to include what looks to my eye like the three best of many ways to screen for colon cancer. You can discuss others with the gastroenterologist or me.

Data on effectiveness suffers from the usual difficulty and confusion so I will lay out what I think is the most useful data to explain these three tests:

A 2014 study comparing the cheap stool test given by Sloan at your annual exam and a new DNA stool test (AKA "expensive stool test") with colonoscopy reported that to detect one cancer, cheap stool testing would need to screen 208 people, DNA testing 166 people, and colonoscopy 154 people. The source of this data said, "whether stool DNA testing will improve testing adherence over colonoscopy remains to be seen." True, but perhaps more people might be expected to collect a stool and send it off than do all involved in colonoscopy.

These figures imply colonoscopy will save more lives, DNA perhaps a close second and cheap-stool the least. It also matters that colonoscopy removes polyps so "prevents" some cancers. Stool DNA can detect some polyps as well, though it would seem likely visual colonoscopy would do so better. The stool-DNA, perhaps uncommonly, might detect a polyp missed by colonoscopy.

If cheap-stool or DNA-stool are abnormal, a colonoscopy should *then* be done.

How much do we reduce death with each test? Hard to say as studies conflict. For colonoscopy some are critical of its effectiveness and others as optimistic as 90%. I think realistic may be in the neighborhood of 60% and maybe improving with recent understanding of how flat polyps have been elusive so better efforts are being made to detect these. The clear understanding that increased time spent by the gastroenterologist detects more is also new information and accountability for this is increasing.

Stool-DNA probably comes in as a good second place finish and likely closer to colonoscopy than the 32% reduction in death from colon cancer that we get by doing the Sloan-office, cheap-stool test every year.

Colonoscopy is advised every ten years starting at 50 for those who choose colonoscopy. Quitting when age 75 or less than 10 years of life expectancy, if that is earlier than 75, seems wise.

Cheap-stool testing is advised every year starting at 40 and every year you do not have colonoscopy or a stool-DNA test. The quit-rule of thumb is the same as for colonoscopy.

Expensive stool DNA cost something like $600 and is covered every 3 years by Medicare and more insurances every day as it is new from 2014. Good science does not yet suggest a best interval, but the three-year plan makes the common sense of it entailing less danger and less cost than colonoscopy. Also, since it is seemingly not quite as effective as colonoscopy, "giving it more chances" makes sense – remember, it usually takes ten years to go from nothing to cancer that has spread, so three opportunities in ten years might make sense.

The stool-DNA test is not recommended for people as described above with first degree relatives with colon cancer nor those with prior polyps.

Because stool-DNA is new, it has not had time for the smoke-filled-room of medical consensus advice to trickle down to you and me. When that several-years process is completed, knowing what I do of screening science, I think the bright guys in this field may voice strong favor for stool-DNA because a principle of screening science is to do the most good for the least harm and though colonoscopy may do more good, it comes with more harm as well.

As it stands now, I think proper is to observe colonoscopy is most effective. The expensive-stool DNA is far more effective than NOT doing colonoscopy and the cheap stool every year you don't have a colonoscopy or stool-DNA is smart.

As in everything, it stands for you to decide best for you. If you simply consider, DECIDE and act, that would seem a best-fit for you and certainly superior to procrastination.

Feel free to ask me more about these.

LUNG CANCER SCREENING

Having been a doctor who made the mistake in the 1980's of doing routine screening chest x-rays in smokers, only to find we caused harm and did no good, my enthusiasm is perhaps low for new guidelines for screening by CT scan. The guidelines call for CT scan IF you smoke, have quit less than 15 years ago AND have smoked "30 pack-years or more". Pack-years are simply the average number of packs per day you have smoked, multiplied by the number of years you have smoked.

So, if you quit smoking more than 15 years ago, no screening is recommended. If you smoked 40 years, half a pack a day, that is 20 pack-years. It takes 30 pack-years for screening to be advised so you should not be screened. If you are over 80, have limited life expectancy or are not willing or able to have curative lung surgery--you should not be screened.

Here is all that, restated by the U.S. preventive services task force:

"Annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery."

It is a given that the best way to deal with lung cancer risk is to succeed in quitting smoking, but let's look at benefits and harms from screening: If you screened from age 55 to 80, that would be 25 scans in 25 years. Doing so will give an approximately 1.85% better chance of not dying, compared to those who do not screen. If you screen less than every year for 25 years, the benefit number would be lower.

Now, let's look at what might be involved if you screen every year for 25 years: First, there is a 24% chance with the first three scans we will call and tell you there is a "problem". This number will be higher over 25 years. Thankfully, 96% of these "scary phone calls" do not wind up being cancer though there will likely be some anxious times. (Remember, in 25 years of this, you are doing it for a 1.85% better chance of not dying.)

These phone calls first result in our telling you to repeat some kind of imaging, sometimes for many months and even years, with whatever anxiety that might provoke. However, in addition to extra time and studies, the first three of perhaps 25 scans will also call for an invasive test, whether needle or surgery, 2.7% of the time. This number will be higher over 25 years. (If scanned all 25 years you have a 1.85% better chance of not dying, less benefit if not scanned 25 times in 25 years).

Recall that with breast, prostate and thyroid cancer, we have the situation of MANY being diagnosed who would never have been harmed by their cancer. No doubt there will be *some* of this with lung cancer screening i.e., you get diagnosed with lung cancer but it does not help you because you were not destined to be harmed by it. However, unlike breast, thyroid and prostate, there are not many such "friendly" lung cancers so I do not consider this as significant.

As a self-defense doctor, the advice is as stated above and if you want to participate, simply inform me and we will arrange this CT scan with no IV contrast be done and I will send you a letter when I get results.

As always, discussing this further with me is welcomed.

CERVICAL CANCER SCREENING – PAP SMEAR

The details of cervical cancer screening are beyond what I do as an internist but the information below is sturdy and may help in working with your gynecologist. I am happy to discuss any parts not well-understood.

For average risk women, the USPSTF recommends screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

Women Older Than Age 65 Years

Clinicians and patients should base the decision to end screening on whether the patient meets the criteria for adequate prior testing and appropriate follow-up per established guidelines. The ACS/ASCCP/ASCP guidelines define adequate prior screening as three consecutive negative cytology results or two consecutive negative HPV results within 10 years before cessation of screening, with the most recent test occurring within five years.

They further state that routine screening should continue for at least twenty years after spontaneous regression or appropriate management of a high-grade precancerous lesion, even if this extends screening past age 65 years. The ACS further states that screening should not resume after cessation in women older than age 65 years, even if a woman reports having a new sexual partner.

BLADDER AND KIDNEY CANCER SCREENING

Older guidelines endorsed routinely doing a urine specimen over age 60 to screen for cancer and I have done so for years. Newer guidelines do NOT suggest this and I believe it is most appropriate we quit doing a routine urine.

Certainly, any blood in the urine or urinary tract symptoms of burning, frequency or pain will continue to merit evaluation.

SKIN CANCER SCREENING

To my surprise, there are not vigorous suggestions regarding skin cancer screening so I am going to give advice because common sense and experience tell me that, of course, early detection will save lives. Importantly, though it may cost in time, money and anxiety, these are relatively trivial harms compared to the prices you pay for appropriate colon, breast and other screens because our invasiveness is limited to the relatively harmless business of skin.

I suggest a first, total-body skin exam by a dermatologist be done at age 18.

In our sunny part of the world, I believe the fact that I do not examine ALL skin surfaces and lack full expertise makes a formal, full-body skin exam by a dermatologist wise. When you call for the appointment, specify that you want this so appropriate time is booked. Ask the dermatologist when, if ever, such a full exam should be repeated for best guidance. Some people might not need such very often, others very regularly, depending on what is found and other factors.

I believe a proper, thorough skin examination is beyond the talents of an internist. I look at your skin quite a bit during annual exams, keep an eye out for abnormalities and find and refer a fair number of cancers but this skin exam is not comprehensive.

VACCINES

There are a lot of vaccines for special instances that I will not cover until the special circumstance arises. The following make sense for all of us. Most vaccines are now given at the pharmacy – I will write a "prescription" that serves more as a note to remind and specify what we all have in mind – often a prescription is not required.

Flu – My personal rule of thumb is I avoid the chatter and always get the flu shot because flu is miserable and has a chance of knocking years off my life by making me dead after being miserable. The modern vaccine is little different than placebo in side effects, though years ago the shot gave plenty of people a few day's misery that has some saying they don't want to take it again. The older you get, the more the flu might ruin you so it might be worth trying again.

Skip all the news story hype about how well the vaccine matched, etc. Even in years when the match is poor, vaccine recipients get less flu and less severe flu. We carry a limited supply but best rule of thumb is get it when and where you see it.

We used to suggest when to get it but the new rule of thumb is get it as soon as it is available each year, usually early Fall. Get it even if you are running late as we see flu every month these days, likely due to so much world-travel bringing it to non-travelers – no such thing as "too late" to get the shot.

If you are over 65, I recommend the “double dose” flu shot but if they are out when you are there, instead get the “regular” shot right then.

Pneumonia – This vaccine became a bit more confusing when a new, better version came out in 2014, so working with your records and your pharmacy is best. The “old” vaccine we will call “23” and the new, better, “13”.

If you never had a pneumonia shot: age 65 get the 13 and a year later, get the 23. No boosters needed.

If you have had the 23 after age 65: at least a year later, get the 13.

If you had a 23 before age 65: get the 13 at least a year later AND, we still want you to have a 23 dose AFTER you turn 65.

If you have an immune problem, diabetes, heart or lung disease, get these shots before age 65, otherwise at age 65. At present, no 13 booster is advised.

Shingles – Two things worth noting: it is a LIVE virus vaccine (severely weakened but live) so should not be given if you have an immune problem. Ask if any doubt. Secondly, though you have a one in three lifetime chance of getting shingles and CAN get it again if you have had it before and, though it often hurts badly and sometimes hurts for a prolonged, indefinite time, though it can harm vision if involving the eye, shingles seldom kills anyone so if you are vaccine averse, it is not as imprudent to skip this vaccine as it is to skip flu and pneumonia vaccine – I got the vaccine – shingles HURTS!

Because the vaccine was less effective than we hoped in 60 year olds, I suggest get it at age 50 when humans mount better immune responses. Some insurances will not pay until age 60, leaving you a financial decision to make – the medical decision is a no-brainer in my view and I reached into my pocket and bought it early.

It is not licensed for under age 50 and IS advised even if you have had shingles, but wait till one year afterward. At present no booster is advised.

Pertussis, tetanus – When we were kids we received the pertussis or "whooping cough" shot and at older age the vaccine gave some fever and seizures so we quit giving it for decades and everything worked fine. A few years back, this disease that can kill newborns made a comeback as our immunity waned. Middle-aged/older folks get this highly contagious disease and, tragically, can give it to helpless newborns, so an adult vaccine-booster that does not cause fever and seizures was developed: **Tdap**. Get it once, regardless of when last tetanus was. You need tetanus every 10 years and Tdap contains tetanus. At present no booster is advised.

HPV – The human papilloma virus can cause cancer of the cervix in women and cancer of the oral cavity and anal-genital warts in both sexes. The virus is sexually transmitted.

The 9-Valent vaccine should be given at age 11 and can be given up to age 26. After age 26, the vaccine is not advised.

OSTEOPOROSIS IN MEN AND WOMEN

Take a few minutes and maybe learn something new about thinning bones because we have probably made this confusing and perhaps a bit overdone. This subject is much better decided by your personal views and preference than a lot of things we do together – men and women.

Let's dispense with terminology first: osteo**penia** means thinner bones but not yet osteo**porosis** which means "too thin". Though sex, genetics, race, body-build,

alcohol and tobacco matter, I get surprised all the time by who does and does not get these "natural-enough" conditions (thin, white female who smokes, drinks alcohol and has a mom with osteoporosis, is the worst risk but some of these folks, none-the-less, have great bone density and vice-versa).

I like the guidance of the U.S. Preventive Services Task Force just fine:

The USPSTF recommends screening for osteoporosis in women aged 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year old white women who has no additional risk factors.

Said a different way, "don't do bone density if you do not meet these criteria."

If you are 50-64, it is slightly convoluted, but worth it to figure out if you have the risk of the unrisky 65 year old and therefore should get bone density testing. To do so, Google “Frax” and plug in the calculation tool. If your 10-year-risk of “major osteoporotic” on the frax calculation is 9.3% or greater, get bone density testing, otherwise wait till age 65.

Good reasons to wait to be tested include not just time, money and concern but also that bone density does not do an excellent but rather only a “somewhat useful” job of predicting who will get a fracture. Further, our treatments also do not do an excellent but rather only “useful” job of decreasing the number of fractures – probably most useful is DO NOT FALL – partly by being careful and partly by staying in good physical condition.

There is reason to be concerned with our treatments over a long period of time, so “waiting” to be tested till closer to when osteoporosis becomes a bigger problem makes good sense.

Osteopenia should not be treated with medicine, only **osteoporosis** should. All of us do well to get weight bearing exercise like walking for lower body and weights for upper body to help against osteoporosis. I think Vitamin D 800-2000 mg per day might help, though data is not fully supportive and I think getting calcium in your diet is a good idea with supplemental calcium no longer recommended over concerns it might harm arterial health and is not necessary.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men. That said, if a guy is quite old and thin and has a personal preference to be screened, that seems reasonable, though I would not recommend such before age 70.

I am happy to discuss this more if you prefer.

SONOGRAM FOR ABDOMINAL ANEURYSM

This is only recommended once, for men only, age 65-75 only, who have ever smoked more than 100 cigarettes. My enthusiasm for this is tepid as our certainty of net benefit is less clear that with, say, colonoscopy.

The test might save a life by identifying an aneurysm before rupture makes emergency surgery less likely to be successful. However, the odds of detecting a small aneurysm to be followed for years or of our advising elective surgery and it not go well – these odds are not small.

Back in the day, I had my 100 cigarettes and I doubt I will do this test as I value avoiding medical mischief higher than taking an elective chance to avoid an emergency chance. If you prefer the former, just ask and we will order it to be done next door.

HIV TESTING

One of the many guidelines says simply, “screen for HIV age 15-65 and others who are at increased risk.”

I do not routinely do this because it requires your written permission, costs you money, has often already been done on insurance or other exams and because the risk in those without risky behavior is small.

If you want the test, ask. If you have had unprotected sex with men or women of unknown or positive HIV status or use IV drugs and share dirty needles, please get the test.

HEPATITIS C TESTING

USPSTF recommends I offer one-time screening if you were born between 1945 and 1965. You *should* be screened if you are high risk from injection drug use, ever, or from blood transfusion before 1993. If you want this test, simply tell us.

I DO NOT *WANT* CANCER

As you read today, my hope is you will gain good understanding about cancer and then wrap it into a neat package, put it on a shelf and forget it. I also hope you will solidify ideas about what you would do if you *did* get cancer that will make it go better for you than if you wait and the shock and disappointment lead you on a less-than-best path we have all observed in others.

Who among us has not watched another person with cancer going through things we tell ourselves *we* would not do, and yet . . .

LET'S PREVENT IT

Pick your parents wisely.

Don't smoke.

One could be forgiven for saying this is *most* of cancer prevention. It is true some heavy chemical and asbestos exposures are worth avoiding and it is true enough that alcohol can help some get liver and other cancers they were not supposed to have, but the numbers are not huge. (Big enough to add to the list of reasons to de-booze though.)

It is also true that obesity increases some cancers but not so very much. Try to eat and exercise well but fretting too much about a cancer increase over something your fellow humans seem to be especially poor at accomplishing (weight loss) seems a bit hard on the spirit of the only life you have been granted.

Avoiding preserved meats, getting HPV vaccines (prevents sexually transmitted virus that can cause cancer) – the list is long but finite and worthy of whatever attention you want to give it. Except for avoiding smoking, most items on the list,

all adhered to perfectly, may not afford any of us as much protection as the decision to wear a seat belt and stay off a motorcycle. For those who want to *not* obsess about cancer risk everywhere, it is hard to argue too strongly with that.

Too late on that choosing your parents thing but recall that if your parents had cancer, you are still more likely to ***not*** get their cancer, though it is true you are slightly more prone than your friend whose parents did not have cancer.

Smoking risk is well known. Less well appreciated is how quitting will, fairly quickly, pay off by lowering the risk of damage done. Quitting is the great idea but even those who do not are not a slam-dunk to get cancer. Currently if you don't smoke, you have done the best of cancer prevention – if you smoke, you *can* quit.

LET'S SCREEN FOR IT

I BELIEVE CANCER SCREENING HAS VALUE.

The reason this is written in bold is so that when I emphasize that cancer screening can cause a tremendous amount of *harm* (a fact no one who knows the subject disagrees with) I want to be clear that I not only participate in cancer screening myself, as a patient, but I believe it also has square-deal value for my patients. *But* . . .

Bad screening ideas have been foisted onto patients from the usual suspects: our (physician) ignorance, bias, good intentions or self-interest – in most cases by overenthusiastic or wishful promotion of ideas that sounded good but we got ahead of the science.

The reason it is so easy for us all (doctors and patients) to fall into this trap is we all hate cancer and naturally embrace ideas about beating it.

Screening for any disease, whether blood pressure, cholesterol or cancer very quickly starts causing harms that had better be worth it in benefits. Even concerning the *few* cancers for which we have clearly demonstrated benefit, the *harms* are very real and it is reasonable for you to weigh the information and decide.

COULD YOU BE MORE SPECIFIC, PLEASE?

Here goes. Most cancers are easy to dismiss for screening because "no way" do we have tests that cause more *good* than harm. For example, we do not advise yearly brain MRI for brain cancer screening because it is not the nature of brain cancer that outcomes are determined frequently enough by early detection to justify the harm of all the pursuit of things found on MRI.

Cost and time matter but not as much. The fact that brain cancer is somewhat uncommon also matters – ditto adrenal gland, bile duct, liver – most body parts that can get cancer do not have screening tests that overcome the hurdle of more good than harm – I am glad we are all working on that world-view/philosophy thing since we all face the possibility of cancer that cannot be found early nor successfully treated. (Or, our airplane can go down or we might get incurable Kuchimanga.)

Some cancer screenings are clearly good, like PAP smears for cervical cancer and looking for suspicious skin spots to decrease skin cancer deaths.

Some cancer screenings are heart-breaking. I hate ovarian cancer – who doesn't. There is a blood test that is a useful marker to follow progress in patients we know *have* ovarian cancer.

We *wish* this test would be a good *screen* for ovarian cancer but it has turned out not to be. How people do with ovarian cancer seems to depend on the innate meanness of the specific kind they have and/or the cancer's specific characteristics of responding to treatment.

Our wishing the blood test would find the bad ones early enough to change the outcome has not made it so and the same is true for a similar colon cancer blood marker – not useful for screening.

Though lingering controversy remains with prostate cancer blood testing, the same concept applies: it seems the bad cancers that intend to kill elude blood testing efforts, leaving mostly only *harms* greatly outweighing either no benefit or "too little" benefit to be a fair deal.

Some cancer screenings were stupid. In hopes of decreasing lung cancer death, many physicians in the 1980's, including me, did yearly chest x-rays in smokers, as common sense suggested early detection would benefit. We had no science to prove it but we had understandable wishes and the best of intentions. It turns out we gave many patients a severe, controlled mugging in the form of chest surgery, ICU stays, death, complications and eight weeks off work for their *benign* chest shadow.

Others had cancer we caught early, but, surprisingly, this did *not* save lives – the incidence of death stayed the same. What this *did* do was convert them from being care-free and unknowing, living a full life, to them and their family being 100% absorbed in the fight against cancer *earlier* than they would have been, *but* with the same outcome. Needless to say, we have stopped doing yearly chest x-rays in smokers.

I plead with you to be savvier than us doctors and move away from thinking, "Well, it is just an x-ray, blood test, smear, procedure (or whatever). What's the harm in that?"

The harm of such ill-advised "fishing" is it begins the cascade of mischief that can arise and it is a terrible deal when not accompanied by enough benefit.

THIS GETS HARDER

Finally, some cancer screening can be controversial or uncertain. This is where your talent for fact-based understanding followed by *you* deciding, based on your informed preference, might save your life or save you misery for no good reason, sometimes depending on your personal preference.

The two obvious cancers in this are breast and prostate. Current, best consensus-opinion voices some favor for mammography and doubt about PSA. Both have been discussed in earlier sections.

WHAT ELSE ABOUT CANCER?

Some good habits to avoid cancer, some useful screenings to improve chances – good so far. Treatment to survive and, if not, experiencing a good death, complete what it takes to understand cancer *before* the subject arises.

A little time *now* thinking about treatment and the possibility of not surviving may help you avoid what can be some of the meanest things that can happen in health care, and that is: **cancer care gone wrong**.

CANCER TREAMENT

I think cancer treatment decisions can be pretty easy when any one of us clearly understands our unique situation. I suspect many of us never do, partly because of our own psychology and partly because every single case is different. There are reasons unique to cancer that make clear understanding too-often unlikely. Let's look at it.

PSYCH ME OUT

Studies show the make-up of many of us includes a desire to never be clearly told bad news, like incurable cancer. Other studies show some physicians are reluctant to be so stark as to clearly say a patient cannot be cured. (Perhaps that could be just as it should be; one patient doesn't want to hear it and perhaps his doctor obliges by not saying so.) Still other studies show patients go through even horrific treatments, articulating a belief they are *curable* when that has never been one of the possibilities – they either misunderstood, were not told or just did not choose to hear it.

It is not entirely clear to me whether this is reasonable, regrettable or terrible – probably different in different cases.

Consider how the old, sick guy who is fabulously not ready to go will not hear anything about "not curable", opt for perhaps not-so-bad but futile treatment, maybe experience a bit more harm than good, but maybe "he did it his way". This does not have to be harshly judged as such a bad thing – maybe reasonable – maybe he is well-served by "his way".

On the other hand, same guy, same treatment. He goes through his fortune and experiences awful side effects from hopeless treatment. The family, maybe frail themselves, are also dragged through the misery and perhaps the treatment *prolonged* their collective agony. Maybe this rises to the level of "bad" – I don't know.

Maybe the treatment had pretty good prospects to help, even if not cure. Maybe choosing such was very reasonable, even if it did not work well. Maybe just a little regrettably, it did not work out.

Maybe the treatment doctor did not make the prospects of treatment and side-effects clear and the treatment course was a disaster for the patient and family who may have been working a bit of denial. Maybe the doctor stood to gain by treating – maybe some of this came pretty close to a bit criminal?

I am not prepared to insist just how anyone else's psychology should be on such a significant, personal matter – whatever you bring to the table is fine.

I *am* prepared to challenge you to think it through *before* a diagnosis so that what you bring to the challenge reflects your best judgment rather than your shocked reaction – none of us do *that* as well.

The reason it is probably worth the effort now is that too often, the shock of the moment has some folks numbly choosing a path their less-shocked sensibilities might not. **Taking a path that you would not choose when you are at your best is a bad outcome.**

SO WHAT WILL I USE THIS BEST-OF-MY-PSYCHOLOGY FOR?

More than anything, I wish studies would show that cancer patients clearly understood, *before* choosing treatment, whether they were considered **curable, incurable or a certain percent chance of curable** – studies do *not* show this.

Good psychology is the start of you being determined to wade through the noise and get clarification. Remember the bit about "History, Physical, spoken assessment, tests and clarification so that the next step reflects *your* judgment."

Most all of us will choose most anything if the choice is near certain death without the treatment and near certain survival with it. That seems as it should be.

With a clear understanding that we are not curable, regardless of treatment, some of us might opt for hospice fairly quickly and others reasonably explore treatment that will not cure but might give a bit longer life and/or a bit *better* life.

This is where I see the most problems. In the last five or ten years, I think a number of "palliative" (no cure but perhaps improvement) treatments have emerged that *are* worth considering – they might be pretty easy to take and might deliver a pretty solid gain in quantity and quality of life.

I can't generalize about these as some are great and some ridiculous and each person with cancer unique. I *can* observe, even with such treatments improving quite a bit recently, there is still quite a bit more choosing dreadful, futile treatments that I personally might not choose. The issue is for the cancer patient to understand his prospects as clearly as he can and let's all hope it is him, at his best, deciding what will be done.

Big problem: cancer variables are now so complex it is not possible for doctors like me to accurately frame your prospects and options. A number of studies demonstrate this is often done poorly by cancer doctors, though some oncologists do this *so* very well. Studies show anything from oncologist bias to reluctance to give bad news, to feeling it is wrong not to offer hope, to institutional bias toward action or enrollment in studies or financial incentives for physicians – all can make getting a clear idea of your situation a minefield.

If you pair up shocked psychology with biased advice, I think this often has spectators like me, friends, families and nurses shaking our heads and claiming our friend with cancer is choosing things we would not do.

To the extent such choices are those of a guy who has his eyes wide open and understands *exactly* what he is doing, I say, "Bravo" and forget about the second-guessing peanut-gallery. But, if a little thought *now* causes one to choose things

that spare him and his family unhelpful prolongation and misery, well, also "Bravo".

OK, I HAVE GOOD PSYCHOLOGY – HOW DO I GET CLARIFICATION?

You are over the shock and you know the potential pitfalls of the oncologist talking to you – you are ready. The first step is the clear, brutal articulation of ***curable, not curable, or maybe curable***. If it is curable – go, get cured – hallelujah!

Let's take "not curable" next. That is a shocking, final word and the first time you hear it, it is probably best to appreciate that the anger, denial and bargaining you have read about are natural enough but they are not your friends. Acceptance is.

Plan to take some time to think about what you really want if it is not curable – plan to *not* leap at whatever treatment is offered – studies show a lot of patients have *better* outcomes when they forego such treatments and instead choose palliative and hospice care. Let me say that again as it is the reason to draw your own conclusions instead of allowing numbness to steal from you, your family and friends: **some patients have *better* outcomes when they choose to forego cancer treatments**. (Again, two excellent Internet searches: 1) Frontline: Being Mortal and 2) How Doctors Die – Ken Murray, M.D.)

When it is not curable, the lingo is often confusing. The word "palliative" refers to chemo, surgery, radiation, medications or other treatment that cannot cure but can make remaining life better. Whether denial, duplicity or misunderstanding, it is common for incurable patients to be offered and accept cancer treatment and talk about "beating cancer". Like I said, maybe this is reasonable but it seldom seems so. It *does* matter that sometimes our well-intentioned palliative efforts make things worse with radiation burns, surgery complications or sometimes dreadful chemotherapy side effects.

If you get a disappointing but rock-solid clarity that you cannot be cured and are expected to die of the cancer, that is a start to making the best of your remaining time – I believe few do, but again, maybe what "too often" unfolds is really "just fine" and "the way it should be".

For me, I would be pressing the oncologist till I had a clear guesstimate of how long I have – the TV docs are great at this but in real life, I know we get it wrong. The studies show whatever we tell you about how much time you have left tends to be overly-optimistic – think a bit shorter than we say.

My personal "plan" for me, not for you (that would be *your* choice) is to mostly have no treatment for my incurable cancer, immediately get a palliative care doctor involved which means I can still pursue any treatment I elect but will have a doctor who is good at problem-solving for my comfort. These doctors usually do the work full time and they are generally internists or family doctors with this emphasis, interest and experience and only a few have more specialized training. Studies show most folks get these good doctors involved "too late".

Closer to my death, this same palliative care doctor can serve as my hospice doctor when I choose to change my status to this artificial category called "hospice", which means, "Comfort care only". One doctor, just doing good work, trying to give me best life until my "good death". Most of these physicians will tell you my good death is their specialty.

Insurance cared whether I designated palliative or hospice and hospice means they don't pay for "cancer fighting". BUT, I can revoke the "hospice" designation at any moment and have any treatment I choose. Speaking of which. . .

Not all "incurable" cancers would logically call for *only* comfort care and avoidance of chemo, surgery or radiation. Some cancers may not be curable but have "easy enough" treatments that provide "maybe years" of extra quantity and better quality of life – I will certainly try those. A good general guide is: **if I am in pretty good condition, treatments that can't cure but may help are more likely to be "good". If I am in worse cancer-shape, these treatments have a higher probability of worsening the limited time I have left.**

Problem: other incurable cancers have studies that show some small extensions to a pretty miserable life with some pretty raunchy treatments. I still see too many of these "bad deals". However, maybe these are *not* bad deals but rather the best for a family struggling with a disappointing disease. If so, go for it.

I think problems arise when “unready” psychology meets poor articulation by the doctor. I have had oncologists describe pretty rotten chemo as “not bad”, maybe because they have seen worse, have seen the occasional great response or maybe from self-interest or other bias.

With some of these types of “palliative” treatments getting better and better, let me outline how I would approach it myself: (Here, “palliative” also means “not curative, but designed to make life better.”)

First, I need the guesstimate of how long I have without treatment, and then I need to know *exactly* what the studies show the treatment does. Many of the treatments prolong life at the expense of quality of life but *some* treatments really can make life quite a bit longer with little or no ill effects or maybe even *improved* quality.

For me, spending my remaining time in plastic chairs, waiting on doctors, my schedule and world clogged by the next test, treatment and appointment, my family and friends caught up in my problem – this is a very steep price. For someone else, that “activity” and “hope” may be the best thing.

So, for me, surgery, radiation or chemo that, on average, promises extra months with some sacrifice of quality? No way! Primarily because I don’t want to spend my remaining time being a part of the whole enterprise – the next guy will take great comfort in being a part and I say that is fine. I don’t want to see *you* be a part if it represents not-your-best response from shock, fear, disappointment and confusion.

I am also cognizant of how fighting my cancer that cannot be cured can increase and prolong the strain on friends and family – I *might* ask them to endure that, but it will come from my clearly discerning there is enough value.

If I am on the fence about participating in some treatment, I might dip my toe in and try, with an idea of quitting at the first sign of “not worth it”. This idea is also worth repeating: **I do not believe I see enough folks try and then *quit* their chemo treatments** because they decide, “Not worth it”.

If the minefield of psychology and accurate communication have made it clear one cannot be cured and will die of the cancer, it can still be reasonable to *try* chemo. If it were me trying such, I believe I would quit if I encountered much downside. In real life, I seldom see such quitting, but somewhat often observe remaining time being spent in difficult, ineffective treatment, with people just met, instead of with old friends.

In forgoing treatment that the bias of my caring family or my well-meaning internist and the can't-help-it, biased, cancer doctors might all favor, I am not bothered at all that "sometimes people do really well" – you know, sometimes they really do – they do not survive, but they do better than expected. I think that more often, the stress and strain on friends, family and cancer patients are heightened *and* prolonged, when treatments are not halted at "the best time".

Again, when things go "that way", it could be for the best, even if it does not look like it from the outside.

MAYBE A GOOD IDEA

A guy can have incurable cancer, go to the oncologist, surgeon or radiation doctor for treatment, tell me *early-early* he also wants a palliative care doctor to come on his case (they can help with practical problems like chemo side-effects). The palliative care physician might be a valuable help a bit later in giving signals that perhaps stopping unlikely treatment is a good idea. They can also be a big help in an unhurried, seamless transition to hospice care at the right time *you* choose.

I suggest incurable cancer patients ask me to put in a palliative care consultation the same day they decide whether they will or will not start treatment. Palliative care doctors also on the case make sense right then with either choice. Studies and my experience show almost all oncologists call for this too late, if ever, so ask me to call them – *you are in charge*, not the oncologist. The palliative care people usually come to *you* – no waiting-room, plastic chairs.

I think palliative radiation for bone pain is usually fantastic. I would almost never have much surgery that can't cure unless my pain was an extraordinary-type pain that hospice narcotic could not control. Chemo? Chemo is chemo – probably

often overdone, but sometimes, usually predictably, a good deal. Occasionally, a surprisingly good deal – too often, perhaps a crummy deal.

Incurable? Get that guesstimate, discount it, and take charge of what *you* want for your remaining time and the circumstance of your death. Involve a palliative care physician early, regardless of how much or how little you choose to fight it. For the fight, don't take any wooden nickels – gather baldly accurate information about proposed benefits and side effects, realize either choice is fine and should reflect your values. Probably too few cancer patients take those cruises we all talk about.

YEAH, BUT WHAT ABOUT "MAYBE" CURABLE?

Some cancers like lymphoma "might" be ***cured*** with chemo or radical bone marrow transplant and mostly, I think, you gotta go for it – I would.

Some may not be exactly curable but can almost be held at bay, nearly indefinitely, with reasonable side-effects. I think nearly all of us will choose this.

More challenging is when you have the cancer that would certainly not be survivable if it gets away like some colon or breast cancers. We operate and find some nearby spread or not and hope you are cured but there is a well-studied reason we suggest adding chemo or radiation.

I have no clear qualms with this, but *am* concerned there may be a bit more "foregone conclusion" to some of these treatments than is fair to some patients who might be quite prone to prudently prefer to choose less treatment.

Imagine we tell you we hope you are cured by surgery, but further chemo will reduce your likelihood of death by 33%. This might sound like a no-brainer but what if your likelihood of death after surgery is 3% and chemo will reduce it to 2%? (*That* is the "33% reduction".) Hair loss, vomiting and diarrhea now are bad enough but death due to infection, heart failure in later years, burning bladder, chronic diarrhea, cancer later *caused* by the chemo, nerve or lung damage and other issues probably would make this a bad deal.

I am concerned the vulnerability most of us feel when faced with a potentially deadly disease can too easily result in treatments that are presented with a sometimes biased slant that might combine with fear and result in treatments that might not reflect one's true value-choice. The treatments might cause harm, not work or have other regrettable outcomes.

If my concern is valid, it will only be improved on by your going through the exercise of thinking a bit about it beforehand, as you are doing now by reading this. I hope it is never needed, but if it is, I am glad for whatever thought any of us give it in advance. **There are a lot of practical anecdotes of how doctors and nurses do not choose as much cancer treatment as "civilians" do.**

Remission, disease-free survival, progression-free survival, plain survival – the lingo is never ending, confusing, and at times deceptive, perhaps especially for the unprepared guy who might not mind being deceived.

Keep a clear head. You are **curable, incurable** or **maybe curable**. If maybe, any proposed treatment can be expressed to the nearest percent of what its benefit is, i.e. "instead of a 64% chance of survival you would improve to a 73% chance of survival". Though that is, accurately, a 25% reduction in your 36% chance of dying (go through the math in your head), do not let your mind overestimate the benefit as you weigh the harms.

In this example, 100 take the treatment and harms, 64 were going to live anyway so got no benefit, only harm. 27 will still die so did not get the hoped for benefit but did get the harms, so a total of 91 of 100 treated receive only *harm* and *no benefit*. Nine of the 100 will benefit, though the treatment may give them more long-term harm than just during the immediate treatment time.

Whether this example of 10 out of 11 treated patients receiving only the harms, not survival benefit, is a good deal would seem to me to depend *entirely* on your own values and judgments and not one bit on what any of us healthcare types might hint – our job is to articulate your situation in a way that gives clarity. I think, with cancer, we do some of our very *worst* work in this.

Remember, I mentioned that neither wishful thinking nor good and bad intentions change reality in cancer screening and avoidance – the same is far more true and poignant in cancer treatment. Would that none of us would ever be in this spot but many of you already have been and others of us will be, so do a bit more thinking, then put it on the shelf labeled "not me". Take it down only if it ever comes up.

Respect death, but ultimately embrace it – it is what we all have in common. Find a way, now, to poke a finger in the eye of cancer by telling it that it can only kill you and you were going to die someday anyway. Be determined now to not fear it and it loses some of its power and enables you to choose best for you.

PRESCRIPTIONS: DON'T LET IT GET COMPLICATED

- Know the names of your medicines and what they are for. It is a good idea to keep an updated list in your wallet.
- When you receive a written prescription, give it to the pharmacy. We sometimes receive a request for a refill from your pharmacy and in your chart we see that you have already received a written one from us. If you plan to request a refill by phone or email from your pharmacy, please don't accept a written prescription from my staff.
- If your pharmacy is telling you there are no refills left and your bottle says there are, have the pharmacy make the correction while you are there.
- Call your pharmacy before you go to pick up your prescription. Often they have not taken the call off of the doctor's line and you may have to wait.
- Be aware of lab that is due. I never want you to run out of your medicine or to deny a refill because you are overdue for lab. I check your labs as infrequently as I can and still be safe.
- When you come for your annual physical, I give you refills on all your medicines, as well as information when next lab is due. This enables you to have everything you need on time, avoiding phone calls and confusion.
- If we need to fax your prescriptions to a mail order pharmacy, we are happy to, but please make sure we have every number – fax number, ID numbers and anything else we need to make this happen.

- As a matter of office procedure, my staff never leaves for the day until all prescriptions have been handled. If you pay close attention to all of your medicines – what they are, what they are for, how many refills you have available and when you are due for lab, both of us have it easier.
- Thanks.

THE END

I hope this read has given you a lifelong guide that makes you comfortable and gives you best health for the way you want to approach it.

I am certain at least a few tidbits should make things a bit better.

Enjoy the days.