



What's right and wrong *in my world of medicine*

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The developments in medicine during the years that I have enjoyed the privilege of its practice have been, by any standards, extraordinary. The remarkable achievements in less invasive procedures and transplant surgery, as two examples, have had dramatic effects on patient care.

Given that we are able to do so much more for our patients, one must agree that what is right in medicine today outweighs what is wrong. Physicians often disagree about what may be positive or negative, and I, too, my have own biases.



What's right

My internship began in the spring of 1946, at the height of a measles epidemic. Children arrived at the hospital in the throes of encephalitis due to the virus, some stuporous or comatose, others convulsing beyond control, the less serious with raging fever and delirium. Some died; others recovered, but sometimes with varying degrees of brain damage. Meanwhile, survivors of poliomyelitis often contended with permanent paralysis in one or more limbs. I never dreamed that these dreadful infections would eventually be controlled in my lifetime.

At that time, some medical professionals believed that tuberculosis (TB) responded to rest. Wealthier patients would go to mountain retreats for long periods of inactivity, while the less affluent were confined to bed. The next attempt to treat TB, seemingly in logical sequence, involved putting the infected lung at rest, collapsing it, by pneumothorax or, for more serious cases, thoracoplasty, and the removal of ribs, resulting in permanent collapse of one side of the chest. Whether the TB patients who recovered did so because of or in spite of these procedures remains a mystery.

Fortunately, the antibiotic era, starting with penicillin, following rapidly on the heels of the bacteriostatic agents (sulfonamides), brought dramatic treatment for bacterial endocarditis, pneumonia, the dreaded streptococcal infections, meningitis, and venereal disease. Streptomycin and adjuvant agents proved effective against tuberculosis. We finally gained the means to control many fatal infections.

I also have the troubling recollection of young women during my residency years admitted to the hospital in shock from blood loss or with high fever, desperately ill with infection. Some did not survive despite all our efforts, and a few died from uterine perforation. These problems, of course, were due to illicit abortions stealthily done under poor conditions. As distasteful as abortion may seem, most physicians in practice today are too young to recall the horrific cases of sepsis and hemorrhage that women presented prior to the procedure's legalization. The sanctimonious politicians who pass laws to protect the lives of "unborn children" do so without any knowledge or understanding of maternal health or fetal dysmorphism. There has seldom been such blatant disregard for the cherished physician-patient relationship as the recent law passed by Congress and supported by President Bush abolishing "late-term abortions." It contains no provision for a hopelessly deformed fetus or the state of the mother's health and was passed under the guise of preventing a rarely used procedure.

Infection control was only a part of the technological revolution that swept medicine and, really, all other fields of endeavor. With it has come the age of specialization and subspecialization. Interventional radiologists now pass catheters through the arterial system for dilating and stenting arteriosclerotic arteries and use thrombotic coils to actually seal off some aneurysms within the brain, reducing the need for craniotomy in some cases.

Drugs for blood pressure control and the many psychotropic and antidepressant agents used today cast an aura of barbarism over our early destructive operations, such as thoracolumbar sympathectomy and frontal lobotomy, to treat hypertension and psychiatric conditions. In other areas aggressive surgery has been replaced by medical measures and less invasive approaches as well.

Diagnostic acumen has improved with the arrival of computerized tomographic scanning, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine. Endoscopic procedures in my own field—directed at pituitary gland tumors, internal brain structures, and spinal disorders—have had spectacular results. And, of course, coronary artery bypass surgery and organ transplants have extended many lives.



hat's wrong

If all these advances represent what is right in medicine—adding years to life expectancy, offering palliation or cure for many problems, and bringing relief from much suffering when little existed in the past—then what possibly is wrong with medicine today? Determining what may be wrong is particularly relevant during an era focused on escalating costs of medical care, increasing numbers of uninsured and because the existing medical systems fail to provide for them and the indigent, and heightening calls once again for universal health care coverage.

Waste

Perhaps the greatest problem lies within the profession itself, as practitioners of medicine come to this great feast with a tendency toward overindulgence. Despite attempts at controlling cost, patients have more diagnostic tests, receive more medications, and undergo more procedures than medical necessity dictates. While modern imaging techniques have made it possible to more accurately determine medical conditions, they are used far out of proportion to their need.

The number of spine or brain MRIs done for the common symptoms of back pain or headache that prove to be normal is evidence enough to show that these studies are conducted excessively. In fact, spinal MRI illuminates the normal degenerative spine changes better than ever, leading to reports of "abnormalities" that do not exist¹ and even to unnecessary spinal surgery. Much of this increased use of technology has been in response to patient demand and physician compliance. Personal injury litigation is awash with such reports of presumed abnormality suggesting a relationship to minor vehicular or workplace trauma.

The demand for MRI has spawned a massive proliferation of expensive imaging equipment; one

company operates a chain of 16 imaging centers. Many hospitals have more than one MRI but need to run them 24 hours a day at monumental cost to the system. Such imaging stands at the top of a list that includes many other diagnostic studies, at times referred to as “defensive medicine,” conducted to prevent malpractice litigation. In reality, liability claims are seldom prevented by excessive tests.

Access

Canadians come to our northern cities at their own expense because it may take as long as six months or more to have an MRI performed in their country. Rationing of care and inordinately long waiting periods for elective treatment are inherent to the nationalized health care system in many nations. On the other hand, our system of private health care, voluntary health insurance, health maintenance organizations, and Medicare and Medicaid still denies access to care for many Americans. At the same time, our attempts at cost containment have been unsatisfactory, largely due to excessive studies and unnecessary treatments and surgery. Would that some common ground could be found between the two systems!

Overmedication

In addition to being overdiagnosed our society is now overmedicated. So many superb drugs have become available—anti-inflammatory agents, antacids, numerous psychotherapeutic agents, drugs to control hypertension and lower cholesterol. However, their widespread use seems excessive, as does that of vitamins and antioxidants. All of these agents are particularly marketed to elderly people, whose television programs, magazines, and newspapers are punctuated with many commercials proclaiming the efficacy of so many pharmaceuticals. Many older people in particular take a number of these drugs in addition to the diuretic, cardiac, and other medications they often need. Recent studies suggesting even further lowering of blood cholesterol must be viewed with skepticism. So many public health statistical reviews have failed in subsequent analysis or have proved of little benefit.

As an example of how freely drugs are prescribed, a friend at age 84 had a typical left cerebral stroke resulting in severe dysphasia and right hemiplegia.

Few events are more frustrating, and his family questioned the eight different drugs prescribed by his physician, including an anticonvulsant and one to keep his blood pressure down. The reason given, to prevent another stroke, in my view had no rational basis. I wrote to his physician, and said that I personally would be unwilling to take any drugs. The logic of preventing another vascular incident escapes me. In fact, I might well accept the risk of another myself as a peaceful event. His daughter has told me of the cost of all this medication, adding a significant drain without evidence of any real benefit. No answer came; the drug therapy continued. This situation is common; I regularly see elderly people who have their lists of seven or eight drugs, many of which they do not need, and I have visited a number of nursing homes in recent years to see people in similar situations subject to the same illogical and costly therapy.

The legislation expanding Medicare coverage to prescription drugs will quite likely open the way for even more exorbitant drug use if there is less financial barrier. As the situation stands, Medicare costs per individual are already twice as high in Manhattan, NY, as in Portland, OR, far greater in Miami, FL, than in Minneapolis, MN.²⁻⁴ Is the harsh Minnesota winter more favorable to the health of the elderly, or is it possible that Floridians and New Yorkers are more demanding and their physicians more amenable? It also appears likely that major costs of medical care are expended on extraordinary treatment during the final six months of life, hardly rational care of the terminally ill.

Unnecessary surgery

More egregious than all of the previously mentioned wrongs is unnecessary surgery. Coronary bypass surgery has undoubtedly saved many patients' lives, but others for whom it has been advised, at times even urgently, have done as well without surgery.⁵ Many patients have had arthroscopic knee surgery, only to fare no better than those receiving nonsurgical treatment.⁶

In neurosurgery the many forms of cervical and lumbar spinal surgery that have evolved have been the source of controversy. In recent years, fusions have experienced a massive renaissance. While the advanced techniques used to perform these operations have resulted in higher success rates, the procedures are inordinately overdone, and many pa-

tients experience inadequate relief of neck or back pain, and some have even more pain as a result of the procedure: the so-called failed spinal surgery syndrome. A small number of these operations have even resulted in various degrees of paralysis. The irony is that most patients with herniated discs and other back problems get better without any treatment or surgery.⁷ They find their problems more tolerable with conservative measures and exercise. In the areas of work-related incidents, motor vehicle accidents, and other injuries involving litigation, excessive surgery of questionable necessity has also been done with a significant failure rate.⁸

Cancer

Unfortunately, we have also become overly enthusiastic about our ability to treat malignancy. False hopes are at times raised with the appearance of each new drug for cancer. Reports of large numbers of patients may show life expectancy extended by five to six months, hardly a noteworthy achievement. The usually fatal brain glioblastoma has little better outcome now than it did in the past. The combination of surgery, radiation, and chemotherapy may defer the inevitable for months or even years. In some centers, however, repeated operations or other measures are conducted when the tumor recurs. These efforts may briefly extend a patient's survival but not the quality of his or her life.

Relief of nonmalignant intractable pain may be a worthwhile objective. Specialties dedicated to pain management, including anesthesiology, physical therapy, and neurosurgery, have been multiplying around the country. Patients with painful disorders are increasingly referred to pain clinics. There, they are treated with a number of injected drugs that work on the nerves, spinal facet joints, and other "trigger points." The physicians who carry out these procedures have opened up a field of medicine aimed at treating people previously considered untreatable. Neurontin, a drug intended for the control of seizures, is widely and excessively used, at times in large doses, as an adjuvant for controlling pain.

The most common pain control procedure is epidural steroid injection, combining a steroid and saline or an anesthetic injected into the spinal canal, intended by its placement to be outside of the dura.

Many of the patients who have had this procedure done have experienced chronic back and neck pain, sometimes after unsuccessful spinal surgery. Most show no signs of an inflammatory disorder. Some patients have gained a measure of pain relief, but the overall results raise serious questions about the value of this procedure.^{9,10} The placebo effect is of course significant, as it is in any group of patients with unexplained pain. The procedure's failure to have any lasting benefit would be of less concern were it not for some disasters—a few injections into the spinal cord, blood clot formation compressing the spinal cord, and some instances of devastating abscess formation as a direct result of the injection.

Alternative medicine

Some patients with diffuse areas of pain are thought to have "fibromyalgia," a condition ascribed commonly to people who exhibit evidence of emotional stress. These individuals typically have undergone trigger point injections at multiple sites over muscle areas said to be painful and tender, without any evidence of underlying objective muscular abnormality. This and a number of other similar conditions have sustained the field of "alternative medicine"—the guise for nonscientific therapies of many types. Alternative it may be; medicine it is not.¹¹

The tendency to depart from conventional therapies has, in some measure, come from physician attitudes. Physicians' disdain for the hypochondriacal or histrionic personality all too often becomes evident. And their frustration in dealing with psychosomatic manifestations of illness as well as their patients' frequent unwillingness to accept them combine, driving this group of patients into the hands of alternative therapists.

As strange as it may seem, incurable conditions still exist, and human beings continue to grasp at any hope, as futile as that effort may be. The more powerful element is the emotion underlying a disease process or causing the symptoms. The term psychosomatic originated more than a half-century ago when we were awakening to the realization that anxiety and emotional stress could have profound effects on gastrointestinal, cardiovascular, and other functions.

Chiropractic leads the field of alternative therapies that use deceptive and misleading practices.

The unique jargon of chiropractic derives from ideas that have no scientific basis. The term “subluxation” denotes displacement or misalignment of vertebrae, often at multiple levels, so that “adjustments” can be made by manipulation of one sort or another to restore alignment of spinal structures. Some chiropractors treat more than the common neck and lower back problems, including asthma, intestinal disorders, and migraines. Objective studies discredit their ability to treat these conditions.¹²

If chiropractic is the frontrunner in alternative therapies, acupuncture runs a close second. Some physicians seem to have accepted this ancient Chinese system, largely those who have found that it has some benefit in treating pain disorders resistant to conventional therapy. Much study has already been undertaken in an attempt to explain how this centuries-old Chinese ritual, which makes no sense at all in terms of modern medicine, can possibly be beneficial.¹³

Those who claim improvement from alternative treatments with few exceptions have often improved despite, rather than because of, the procedures employed. It has been said that it is “time for the scientific community to stop giving alternative medicine a free ride. There cannot be two kinds of medicine—conventional and alternative. There is only one medicine that has been adequately tested and medicine that has not, medicine that works and that which may or may not work.”¹⁴

Medical legal concerns

As someone with experience in medical legal affairs and as physician participation in this area has become more active, some comment must be directed at the depth of social and economic problems related to personal injury, industrial accidents, and medical liability. Unfortunately, physicians, because of their desire to help their patients or to support the cause of a plaintiff or defendant, sometimes provide inaccurate and misleading reports or testimony.

The cause of unscrupulous attorneys would be worthless if not for physicians who confirm exaggerated and prolonged symptoms of injured parties or testify incorrectly to negligence of physicians or hospitals.¹⁵ On the other hand, true negligence and liability should be recognized in a rea-

sonable and just settlement. With ever-increasing premiums for liability insurance causing some physicians to forego coverage, medicine and the law are approaching a crossroads. At one intersection is tort reform, with the capitation of awards and the possibility of professional panels and judges rather than juries. But so far liability reform is stalled at a stop sign in most states. At another intersection is a no-fault system that would provide recognition and settlement to an injured person beyond the legal implications of negligence.

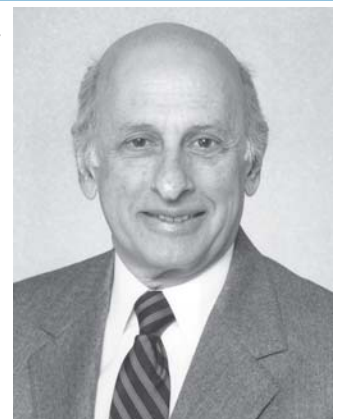
Listening

Much of what is wrong with medicine today can be defined as the extravagance of progress. However, I am an old-fashioned doctor. I try to listen to my patients, as difficult as it can be at times, preferring to hear their symptoms and examine them before looking at their MRIs. Patients today find it difficult to understand why I do not immediately look at the MRI envelope held in the outstretched hand. But they are reassured and relieved when I tell them that their problem does not require surgery, and, not surprisingly, the symptoms frequently become less troublesome. It remains my belief, as I was taught in medical school well over a half-century ago, that listening to patients and examining them continues to be the first and foremost example of what is right in medicine today. □

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Lebanon Chapter, left to right (all MD, FACS): Jaber Abbas, Past-President; George Abi Saad, Secretary-Treasurer; Imad Kaddoura, President-Elect and Program Chair; Michel Daher, President; and Wihbi Shu'ayb, Governor.

presented the chapter with a commemorative charter (see photo, previous page). The Argentina Chapter observed the milestone during the Congress of Surgery conducted by the Association of Argentina Surgeons; more than 3,000 surgeons attended the four-day event. In addition to Dr. Collicott, J. Wayne Meredith, MD, FACS, Chair, ACS Committee on Trauma, also represented the College at this program.

Lebanon Chapter celebrates fortieth anniversary

A gala dinner recognizing the Lebanon Chapter's fortieth anniversary took place September 17, 2004, with 120 guests attending. The dinner has become an annual event, where senior members are honored and new members are welcomed into the chapter.

The President of the Lebanon Chapter, Michel Daher, MD, FACS, addressed the audience and thanked the councilors for their continuous support and work to promote the mission and activities of the chapter. Imad Kaddoura, MD, FACS, chaired the program committee. (See photo, this page.)

2005 Leadership Conference

Save the dates: The 2005 Leadership Conference will be held June 12-14 at the Washington Court Hotel in Washington, DC.

Chapters are encouraged to send their Chapter Officers, two or three Young Surgeons (age 45 or under), and their Chapter Administrator. The College's Washington Office will schedule Capitol Hill visits for all participating chapters.

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