



# Physician Brain. Patient Heart.

David L. Brown, M.D.

A medical insider exposes how powerful incentives inside modern health systems overwhelm patient autonomy.

The logo for Curadux, featuring the word "curadux" in a dark blue, lowercase, sans-serif font. A thin blue arc is positioned above the letters "a" and "d", spanning from the top of the "a" to the top of the "d".



## David L. Brown, M.D.

After practicing medicine and leading departments inside the world's elite healthcare institutions for 38 years, David L. Brown, M.D. thought he understood healthcare, especially end-of-life care. Then, he almost died from multi-organ failure in his own ICU. His illness gave him a gift that no medical training could provide – a first-hand look at how powerful incentives inside our health system quickly overpower the unique values and goals of individual patients. Armed with a physician's brain and a patient's heart, he now has a story to tell.

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# Contents

	Foreword	i
<b>01</b>	Getting started in medicine	1
<b>02</b>	An insider's struggle	7
<b>03</b>	Fragmentation of healthcare	15
<b>04</b>	Moral burden of decisions	23
<b>05</b>	Merging a physician's brain & patient's heart	27
<b>06</b>	Curadox: Steps leading to a solution	33



### **About the Foreword Author**

Rosemary Gibson is founding editor of JAMA Internal Medicine's Less is More narratives series. She is author of The Treatment Trap which puts a human face on overtreatment. At the Robert Wood Johnson Foundation, she was chief architect of its successful \$250 million national strategy to bring palliative care into the nation's acute care hospitals. She is the recipient of the Lifetime Achievement Award from the American Academy of Hospice and Palliative Medicine.

# Foreword

*by Rosemary Gibson*

In a revealing and candid account, *Physician Brain, Patient Heart* chronicles the story of Dr. David Brown and his distinguished career as a physician.

His understanding of 21st century health care changed dramatically when he became a patient and saw the unvarnished health care system from the other side of the bedrails.

On the brink of death in the intensive care unit in the hospital where he worked, his wife and family had to make terrifyingly consequential decisions shrouded in uncertainty.

Rising from near death and grateful for the gift of life, Dr. Brown decided to launch Curadux because he wants to help those who have a complex or chronic illness and are faced with some of the most difficult decisions that we mortals will ever have to make.

At times like this, most of us have little knowledge or experience to guide us. We can feel isolated and alone, not knowing where to turn for help.

In the fragmented health care system, it seems impossible to find someone who has the time to explain what is going on and answer questions through the ups and downs.

Even with the best laid plans, dutifully having completed an advance directive and durable power of attorney, crucial decisions may have to be made frequently about treatments to continue, cease, or forego.

Dr. Brown established Curadux so patients and their families can have someone to walk alongside them and help them understand treatment options, the burdens and benefits, and the impact on the quality of life and length of life.

When patients can talk to someone about what is important to them, they can make decisions that are right for them, consistent with their values and preferences.

Dr. Brown says his passion for helping others is heartfelt. From my conversations with him, this is true beyond measure. Patients and families will be fortunate to benefit from his wisdom. It comes from the struggle and joy of having another crack at life and generously giving back.







# 01

## Getting Started in Medicine

*Background on the author entering medicine*

This is the story of how an academic medical insider spent years developing his physician brain, before becoming a very ill patient and living to tell the story of his journey to having a patient's heart.

My entering medical school was more of a challenge than I ever expected. I grew up in a small town in northeast Nebraska, where Norman Rockwell could have painted quaint images of small-town life. My parents gifted me with a degree of athleticism and intelligence, and during high school I received a letter from the football coach at the US Military Academy, and ended high school with an appointment to the US Military Academy at West Point. I was interested in engineering and the school seemed ideal.

My father spent much of his early adult life in the South Pacific as a Navy medic attached to a U.S. Marine expeditionary force during World War II, and he was not excited about me going to West Point. I also had a new

girlfriend, who lived 50 miles away from me and already attended a state university in Iowa, and using a 17-year-old's judgment, I turned down my appointment to West Point so I could be with her. Subsequently, I enrolled at the only other school I applied to, Iowa State University in Ames Iowa.

When I applied to medical school, my most likely admission was to the University of Wisconsin in Madison. I fully expected admission, and didn't apply to any other school. When I opened my "acceptance letter," the University of Wisconsin Medical School dean's office told me that my GPA didn't meet their minimums, and I was denied admission. Knowing that I had about 3.7 on an un-inflated four-point scale, I traveled to Madison to find out what had happened. The admissions officer told me that my grades simply weren't good enough, and that I had a 2.5 average! Iowa State University had forwarded the wrong transcript, and grades earned by a different David L. Brown attending Iowa State University were used to turn down my application at Wisconsin. An admissions officer told me to apply again next year, as their classes were full for that school year.

For someone who usually succeeded, this was a blow, and the nagging suspicion that I wasn't quite bright enough followed me after I was admitted. I transferred as expected for my clinical years to the University of Minnesota and graduated with Alpha Omega Alpha honors.

I joined the United States Air Force Health Professions

Scholarship Program to offset the cost of medical school, and did my graduate medical training in the United States Air Force in medical centers in California and Texas, and spent time on active duty as a flight surgeon with the 319th Bomb Wing in Grand Forks AFB, North Dakota. Those years seemed to go by rapidly, and my wife, Kath calls them the “lost” years. She didn’t see me much; I was on call every second or third night, and often slept when home.

After completing my anesthesiology residency in San Antonio at Wilford Hall USAF Medical Center, I stayed on the faculty and spent three more years training new physician residents. I shared an exciting time of my life with a group of young physicians caring for patients facing life-threatening illness from trauma, military injury, and even civilian trauma from our neighborhood “knife and gun club” and surrounding freeways. Our blood bank at Wilford Hall was almost always busy, and we typically delivered large amounts of blood to our operating room patients as we resuscitated them.

When my time of obligation to the USAF came to an end, Virginia Mason Clinic in Seattle, Washington recruited me to join their anesthesiology team. Three years later I became the department chair before journeying on to the Mayo Clinic, the University of Iowa, the University of Texas MD Anderson Cancer Center, and finally, the Cleveland Clinic where I held leadership roles within the institutions and in national medical organizations. During my last chair position at the Cleveland Clinic, I had one of the larger anesthesia teams in the country,

with 25 physicians specializing full-time in pain care, nearly 35 physicians specializing in critical care medicine, and 200 more physicians spending almost all their time in the operating rooms delivering complex anesthetic care. Additionally, nearly 300 nurses practiced on our nurse anesthesia teams and many others worked in our Anesthesiology Institute. My 35-plus years of anesthesiology practice and healthcare leadership refined my physician brain. I loved my patients, and I loved the teams I worked with.

My residency training and early years in San Antonio followed me through my career. During those early Texas years, I unknowingly developed hepatitis C, but elected not to undergo treatment for it during most of my career, because of the low cure rates.

In 2011, the FDA approved a new three-drug treatment regimen for hepatitis C that raised the cure rate for my particular genotype to nearly 80%. My hepatologist gave me great advice, telling me to, “take the hit for hepatitis C treatment when you’re healthy enough to take the hit.” Thus, during the fall of 2011, I entered into an expected seven-month course of chemotherapy for hepatitis C with a newly introduced mix of drugs. It was during those months of chemotherapy and the subsequent unexpected critical illness and near-death experience that I experienced the blending of my physician brain with a patient’s heart.







# 02

## An Insider's Struggle

*Physician with longstanding hepatitis C enters treatment and an ICU*

After 35 years of leading large groups of physicians, I thought I knew how healthcare worked. During these years, I also spent time in leadership on the American Board of Anesthesiology, the Accreditation Council for Graduate Medical Education, and the Foundation for Anesthesia Education and Research. Many of my peers looked to me as an “organized medicine insider.” I also had a personal life, and personal health issues. My story became more complicated after my physician and I elected that I undergo treatment for my hepatitis C.

The hepatitis C virus (HCV) is a disease with significant societal and personal impact. My HCV began in the late 1970s in San Antonio, Texas, most likely via an unintended needle stick in my hand while resuscitating a patient who was bleeding to death. In those days, anesthesiologists did not wear gloves, and blood was not checked for HCV, or even HIV. The chronic hepatitis from HCV is often without

symptoms during its early stages. In fact, most people with HCV are unaware of having it until a routine blood test of liver function suggests HCV testing is needed.

My own HCV infection was known almost 30-years before opting for treatment. The main reason for forging ahead with treatment after living with HCV for 30-years was a new treatment regimen with improved outcomes that became available in 2011. Only a month after the regimen became available through the FDA, I began the new three-drug chemotherapy protocol.

The first week of my chemotherapy was not bad: interferon self-injection was quite easy, though the ribavirin, in combination with interferon, did lead to a diminished appetite and near constant nausea. My mood remained near normal – at least in my mind. When the protease inhibitor oral meds were added during the second month things began to change: my nausea increased, and my appetite disappeared. At the end of month two, what little appetite I could muster was only for watermelon and full-sugar Coca-Cola. Occasionally I could tolerate a small piece of steak. My wife became self-conscious going through the checkout line at the Giant Eagle grocery store with only watermelon and Coke in her cart.

About this time, sores erupted over my chest, belly and arms, as well as in my mouth; we called the lesions “my leprosy.” I began shortening my day at the office progressively from ten hours to six hours, and then to four hours. We moved a recliner into my clinic office to allow me to rest intermittently with my legs elevated. My

secretary, Julie, arranged special permission for me to park a bit closer to my office to ease my workday. I became more lightheaded, but still managed to drive the 25-miles between home and my office.

My progressive downhill course was not glaringly obvious to me. It was clear in my mind that I could still make “good” leadership decisions in the moment at the office. Coming home and lying down on the couch to rest was another matter, as was arranging to take my medication on a schedule of every six hours, a rigorous demand of the precisely-timed chemotherapy protocol. I was plain old sick; my combined dizziness and anemia made me look a pasty, and I was slow in gait. During this time I often thought about what I learned as an intern so many years earlier, to declare a patient “sick” and in need of immediate attention, or not so sick. In my mind, I gave myself the benefit of the doubt and classed myself in the “not too sick” group.

I made a very conscious decision to continue my quite typical “walking rounds” at the Cleveland Clinic. I thanked all I met on these rounds for everything they did for our patients while I was getting visibly weaker. I had already removed myself from clinical care of patients after about two weeks into my chemotherapy due to my progressive weakness and lightheadedness, as I did not want to injure my patients. The impact from my medication tested my patience, and I gave extra effort to overlook some of my pet peeves and consciously tried to “suffer fools” with more patience. There is no evidence I succeeded at that.

At home, I had to crawl up to our second-floor bedroom, since I was too lightheaded and weak at the end of the day to walk up the flight of stairs. My wife encouraged me to stop the chemotherapy, as did my liver doctor. He suggested three months into my treatment that my side effects outweighed the possible benefits from chemotherapy. I directly told him, “I do not quit things I start, and I won’t stop the chemotherapy. Let’s just get it done. I can take it.” This stubbornness just about killed me, but that caring physician’s judgment admitted me to the ICU, and in part saved my life.

Two months after that visit, I was admitted to the hospital when my doctor’s exam showed I had significantly low blood pressure and was developing sepsis, an effect of the Epstein Barr virus. Earlier that morning, I needed a car arranged by my secretary to take me into my clinic appointment; too lightheaded to sit up, I lay in the backseat of the driver’s car.

One doesn’t often think of a severe illness as a gift, but that is exactly how I reflect on my near-death experience of 2012. The treatment was rigorous, debilitating, and depressing, but nonetheless, it was a gift. During my chemo, we lost a young family friend, a U.S. Marine in the Afghanistan war, and I sat for hours repeatedly watching his funeral procession on YouTube, one of the only ways I could feel anything during my chemotherapy. I worked daily, but at home I felt exhausted and drifted through an emotional fog. My wife, Kath, could only get a little watermelon and Coca-Cola into me in the last months, and

I wasn't too much fun to live with.

I should have received another month of chemotherapy for my hepatitis C, but an acute illness intervened on top of my weakened state. I ended up in our surgical intensive care unit at the Cleveland Clinic, where for three-and-one-half weeks I went back and forth between unconsciousness and wild delusions. I lost decision-making capacity early. My immune system was nearly gone, and the Epstein Barr virus went wild inside me, resulting in multi-organ failure. My wife and family were faced with decisions about continuing my critical care life support, an intriguing challenge, since I was a patient in my own ICU. Some of my team thought I was suffering, and due to the severity of my illness, believed my treatment to be futile, and that my life support should be compassionately withdrawn. Futility is easier to consider in the abstract, but more difficult for a family to consider when a nearly three-year-old grandson declares, "I love you Papa," as he leaves the strange noises of the ICU behind. My daughter brought her son, thinking the little boy should see his Papa at least once more before he died.

During my ICU stay, many worried I'd bled into my brain, to explain my altered mental state. My platelets were less than 18,000/mm<sup>3</sup> over one four-day interval. My weight was down 50 pounds, and I was totally dependent on nurses and technicians.

I could not speak my thoughts, and my eyes were mostly closed, but my hearing was often active, and I understood much of the talk around my bedside. Clinically, I knew I

was dying, and thought it odd to know the mechanism and time of my death. My family stood at a crossroad, my wife, physician daughter and attorney son tackled whether I was suffering sufficiently – and with no hope of survival – to frame their decision of withdrawing my life support.

### **Recommended Blogs**

“An Insider’s View: What’s Really Wrong With End of Life Care”, June 29, 2016.

“Advanced Illness: What does it really feel like?”, July 27, 2016.







# 03

## Fragmentation of Healthcare

*Examples of fragmentation impacting patients and physicians*

The modern healthcare system is fragmented. Disease-focused ‘care’ has transformed our healthcare systems into corporate institutions often focused on maximizing revenue by delivering as many services as possible to the detriment of delivering personalized care for unique individuals.

Too often, healthcare systems force patients and their families to become inexperienced navigators of confusing organizations, maneuvering through a series of disease-focused consultations without a true coordinating physician on their care team. Fragmentation of care always becomes personal, as a patient’s values get lost in the shuffle of numerous procedures, tests, and appointments.

Patients experience fragmentation most acutely when forced to navigate the health system, trying to find their way through its many specialties and sub-specialties, without a guide to better health. Healthcare fragmentation developed when the system became optimized for revenue

growth, rather than focusing on honoring the patients that need its services. Healthcare organizations have a disease management focus in mind, as they try to manage the effects of organizational consolidation with the desire to grow. The old quip about following the money holds true even in our healthcare systems.

Anyone who has ever tried to deal with health insurance knows it's a tangled web. Payment fragmentation further confuses the healthcare system because the patient receiving the care doesn't actually pay for their procedures. Unfortunately, the physician providing the care doesn't actually know how much their services cost either but intuitively knows they must give as much care as possible to optimize revenue and minimize liabilities from a malpractice suit. All of this leads to an increased number of procedures done to the patient, who, if insured, has no monetary consequences tied to the increase in the amount of care given. Woven into this web are health insurers, the people who end up paying the bill, who have numerous incentives to cut cost by limiting the number of services the patient can receive, to prevent their clients from accepting all the procedures, lab tests, and nights in the hospital ordered by their physician.

As attempts to fix the American healthcare system stumble, private insurers have cut covered services and they add to the growing layer of bureaucracy that surrounds doctors and their patients.

Exacerbating the fragmentation of the healthcare system,

specialty-focused physician education often limits physicians to seeing only their specialty, or their role in care, instead of viewing their patient as a complete individual in need of holistic care from a coordinated team of doctors. Families and patients are left behind in a complex institutions where physicians rush about delivering as much of their specialized care as possible to as many people as possible while the volume-based care model continues.

A report in the [Harvard Business Review](#) by Drs. Mate and Phillips-Compton highlights how fragmentation impacts individual patients stating, “During sudden and unexpected or complex (advanced) illness, an individual or their family are required to become de facto healthcare project managers — a job for which they have no formal training — at a time of incredible emotional and financial stress.” Fragmentation is not limited to lower tier healthcare systems. Even in esteemed healthcare systems fragmentation is ever present.

Our current healthcare system remains focused around revenue generated from the traditional fee for service payment model, in spite of legislative and healthcare leadership voices, suggesting we move to a value-based system of care. Healthcare remains a system that generates most of its bottom line revenue from volume-based care, with surgical and procedural specialties reimbursed most highly by society and insurers. According to Merritt Hawkins survey of 2015, orthopedics, invasive cardiology, neurosurgery and general surgery were the four largest revenue generators for typical health systems. Curadux

seeks to accelerate the needed change to put individuals' values and goals in charge, and actually lowers costs thanks to the elimination of futile care and unwanted medical procedures.

Our firm, Curadux, is dedicated to helping individuals navigate a fragmented healthcare system. My own life threatening illness taught me that physicians must make themselves aware of the fragmented system they operate in and overcome that fragmentation.

Below are lessons talented doctors have relearned about the practice of medicine from their patients.

### **Individuals are treated like statistics and component parts**

*“Our huge and fragmented system can often times leave complex patients in the lurch.”*

*“Patients are not their disease, or their surgery, and they are people living through some of the most vulnerable times in their lives. They place their lives in our hands, and we must never forget that most sacred of bonds.”*

*“There is never a routine surgical case or a straightforward procedure. We really are taking care of unique patients coming to us seeking the best possible care.”*

### **Quality of Care Suffers**

*“A patient watched and endured several people in the intensive care*

*unit try, one after another for about 30 minutes, to start a peripheral intravenous catheter without success. He looked directly at me, and in a low powerful voice with his finger pointed at me, asked, “have you tried?” I realized at that moment, that I, the most senior physician present, was not taking final responsibility for his care, and was too willing to accept that no intravenous could be started. The patient was correct. I was able at that time to start his intravenous catheter.”*

*“Both in the intensive care unit, and in the recovery room, it is imperative for us to respond to patient issues in a timely manner. Furthermore, regardless of the perceived “triviality” of the patient or family member requests, we must respect their questions and concerns. When we are trained to focus on critically ill patients, we cannot forget all the patients need our care.”*

*“I was struck by the fact that this patient could be me, or my husband, one of our friends. Suddenly, the case didn’t seem nearly as frustrating or futile anymore. This was a man who had a home close to my parents, and who had been perfectly functional just one week earlier. This case was an excellent reminder that these are not just patients, but individuals with parents, children, families, and friends just like me. And I was humbled by my previous lack of compassion for a fellow human being.”*

## **Doctors Can’t Connect with Their Patients**

*“What my patient reminded me of is how privileged we are to be able to care for others the way we do. The uniqueness of our position gets lost in the day-to-day routine that dulls our senses to the impact we have in others’ lives, even during times of unimaginable stress.”*

*“This patient was suffering, and the family was suffering. Unique to the situation, was the family’s involvement and their knowledge. The patient’s son was a physician, and the patient’s son-in-law was an internal medicine physician, and the family felt they were being pushed towards something the patient would never want. What I learned was that we as caregivers, and as compassionate people, need to evaluate what we do more closely and challenge this concept of continuing futile care. We need to be a healthcare team and not act like a solitary provider. There has to be a better way to approach situations like this, rather than believing in an isolated captain of the ship mentality. I wish I could say this was the only time I have seen this, but it happens quite frequently.”*

*“While it may be just another day loading the trucks for some, it’s one of the most important days of our patient’s life. They come thousands of miles for definitive cardiac evaluation. We must treat the day with the reverence it deserves.”*

*“Jenny (our patient) not only taught me to listen better, love the sick more have introspection of my actions and to apologize when necessary.”*

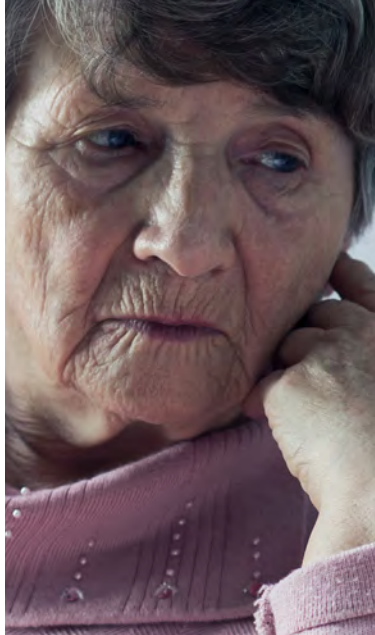
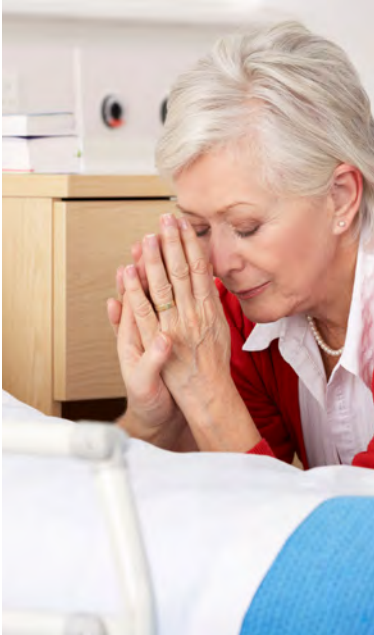
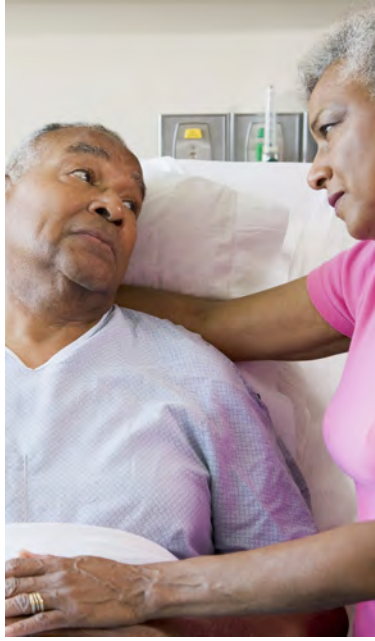
Curadux gives each of its members access to an experienced Physician Care Guide who helps navigate the uncharted waters of our modern healthcare system. Decision guidance from Curadux helps you understand the procedures your care team proposes, their impact on quality of life, and what care options fit with your values. We help you reach your goals.

## **Recommended Blogs**

“Is our health care delivery system fragmented?”, October 05, 2015.

“Why Is Health Care So Fragmented for Patients?”, April 11, 2018.

“Why is health system reform so difficult?”, March 08, 2017.





# 04

## Moral burden of Decisions

*Stories of how families often need help in carrying the moral burden of consequential healthcare decisions*

After patients and families face an unexpected choice relating to healthcare, they often ask: did we do the right thing? Is that what grandpa would have wanted? Did mom suffer too much in the ICU when we wanted the team to keep trying? All these questions relate to the moral burden of making decisions for another person. The weight of these decisions impacts individuals and the family as a whole. The feeling of moral burden is especially heavy when decisions about withdrawing life sustaining treatments must be made.

Most individuals in North America have little first-hand experience with death after it moved out of the home and into our healthcare institutions during the 20th-century, despite the fact that most people would rather die at home than in a hospital. Our culture's inexperience with dying coupled with an overburdened healthcare system leaves

families wondering about how to face death and the moral burden of decision making without experience, a guide, or a counselor.

Curadux Care Guides to walk alongside patients during their experience with a complex or chronic illness. Our decision guidance helps patients and families choose the right care options for their unique situation. We can help frame your consequential decisions, to make them more understandable. Our experience can allow you the time to be present with your loved one, while guiding you through your care options to help you find the right solution. We help eliminate the guilt that comes with deciding care options before a loved one's death.

I believe that it is the physician's job once the family has made a care decision for a loved one to help them cope with the ramifications of that decision, and help them make decisions that respect their loved one's unique values and goals. Doctors can't make decisions for our patients, but should help the family bear the weight of it.

### **Recommended Blogs**

“Moral Burden of Families at the End of Life”, April 27, 2016.

“How do families carry moral burden for loved one's EOL decisions?”, October 04, 2017.

“How caregivers can reduce their own stress during end of life care”, October 05, 2016.

“How to deal with health care decision making overload?”, March 15, 2017.



# 05

## Merging a Physician Brain & Patient Heart

*Living through a near death experience and merging a physician brain with a patient heart comes with work*

As I drifted in and out of consciousness in the ICU that I was responsible for leading, I was deep into treatment for multi-organ failure that developed secondary to my depressed immune system, and an overwhelming infection with the Epstein-Barr virus. Until an expert in infectious disease identified the Epstein-Barr virus as the source of my multi-organ failure, the cause of my critical illness was unknown for over a week of my stay in the ICU.

During my days in the ICU, I underwent dialysis, mechanical ventilation that required tracheal intubation and measures to prevent bedsores. During this critical period of my illness my wife and family had conversations with the critical care physicians about withdrawing life support since I lacked decision-making capacity. Some members of the intensivist team thought I was suffering too much, and continuing care was futile. I continue to thank

my wife for maintaining to the team that I was a fighter and we should give me a chance with a few more days of care. I owe my life to her, my family, my physicians, and God, none of whom ever gave up on me.

I awoke suddenly in the middle of the night three-and-a-half weeks into my ICU stay. I did not know all that had transpired in the 3-and-1/2 weeks, though I did see the dialysis machine in my room and was all too aware of the breathing tube in my trachea. I motioned for the alphabet board and typed the phrase “I’ve never been more alive.” I went on to ask for my wife, and pushed for removal of the breathing tube.

## **A Leader Recovering**

After almost 36-hours of being fully awake while intubated, I finally convinced my intensivists to remove the breathing tube from my windpipe. What a glorious feeling extubation was; it felt like crossing the finish line and winning a race. Those first few breaths were like breathing the sweetest air you can imagine.

Over the course of my illness I lost almost 50 pounds. I needed help standing and needed to be taught to “transfer” myself from the bed to the bedside commode. I advanced to an “old man’s walker” to get me 15 feet to the bathroom. I also used the walker in my reconditioning, taking my nurses and attendants for laps around the ward.

I have fond memories of the Saturday after transferring out

of the ICU when Sarah, my physician-daughter, was able to spend nearly an entire day with me. It was during this time that a trusted friend and treating oncologist explained to both Sarah and me what he thought happened to me. His belief was that I may have simply experienced an unusual case of overwhelming EBV infection accompanied by a systemic inflammatory response that caused the multi-organ failure.

A day after the conversation with my oncologist friend, a “discharge from the hospital” order was made and readmission to the acute rehabilitation unit was accomplished. My admission to the rehabilitation unit indicated that I was getting better, a small step when looking from the outside, but a giant step in my mind. The first afternoon in rehabilitation was spent with a clinical psychologist as well as my rehabilitation physician. With a degree of good fortune, I completed the psychologist’s tasks on the first attempt, and he put in the notes my executive function remained intact.

I had three hours of therapy scheduled each day, in 90 minutes segments, in the morning and afternoon. I was still profoundly anemic, still going through dialysis, and my blood pressure and blood volume were liable. The stiffness of my recovering lungs made breathing with exercise more fatiguing than usual. During this time, small advances seemed like quite a big deal to me. I recall feeling like a star athlete after walking up two steps, in spite of dragging each leg up to the same step one at a time.

After one week—a short interval in that rehabilitation unit—I was discharged home. Riding in the wheel chair to the discharge lounge and waiting for my wife to bring the car around was tangible evidence that I could get back to normal life. The 22-mile ride home was remarkable. I came into the hospital at the tail end of winter and left after seven weeks of warm weather that welcomed green grass and beautiful flowering trees. Each color was more vivid, and each breath was more fragrant than I ever remembered.

About 10 days after I returned home I convinced my wife that she should ride with me and test my driving skills on our not-too-busy neighborhood streets in Westlake. We traveled about five miles round trip and managed to find a Dairy Queen drive-through to make the trip even more interesting. Once my wife reluctantly gave me the keys to my car, life began to take on some normality. These twice a week morning trips to my physical therapy were great mood elevators as independence reentered my life. During all this time away from the daily busyness of work, and with our family's journey so fresh in my mind, I pondered the question of how other families, not as medically connected as ours, functioned in a similar complex illness setting?

## **Leaving Illness Behind**

It is difficult to forget the significance of seven weeks in the hospital and the nearly month-long critical illness of multi-organ failure, but I began returning to work for two to three hours per day, and over another six weeks increased this to eight hours per day before returning to my clinical work.



Over the course of three months I was able to return to a typical 10-hour workday.

During these first few months back in the office I made rounds in the intensive care unit where I spent my illness and thanked all those involved with my care. Over time, the physician and nursing teams occasionally called me to meet with families struggling with a critically ill loved one.

I spent my career as a physician in an operating room anesthetic practice, and in an office and procedural practice of chronic and cancer pain medicine. I truly believed that I really was an empathetic physician. Now my interactions with my patients prior to my illness only scratched the surface of true empathy. It seemed so much easier in the years after my illness, to walk to a patient's bedside and relate to the daily challenges of being a patient.

### **Recommended Blogs**

“Survivorship Following a Prolonged Critical Illness”,  
March 16, 2017.

“A Loved One’s Serious Illness: A Marathon, Not A Sprint”,  
January 13, 2016.



A GA  
**RUN FOR THE WARRIORS.**  
October 14, 2012 ★ Washington, D.C.

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# 06

## Curadux: Steps Leading to a Solution

*After the founder's healing, the story of Curadux launch and adding value to its members*

The question of how other families manage during serious illness kept entering my mind during my recovery. At the time of my illness, I was recognized as a national leader in medicine. My advance directives, durable power of attorney for healthcare and end of life planning were completed far in advance of my illness. My family had another doctor and a lawyer in it and was guided by an unshakeable faith that directed their decision-making. We had planned for everything, yet even they struggled with crucial decisions about continuing my care.

The light went on one day on the drive home from my office. I wanted to help people that found themselves facing a similar health challenge. The obvious solution was to develop a firm that gave families access to physician guidance during their experience with complex, critical and

chronic illnesses.

Early on, I spent a good deal of time thinking about the problem we wanted to solve for others. It was our belief that many patients and families faced complicated decision making while trying to navigate the fragmented healthcare system. We also knew that many healthcare policy discussions are focused around the ethic of utilitarianism, but firmly believed that utilitarianism is the wrong ethic to bring to the bedside of a unique human being facing consequential life-and-death decisions about care.

My vision was that the firm would walk alongside individuals and families facing chronic, complex or critical illness through an elegant tele-health platform, where a physician practicing care guidance, not medicine, could be linked to our members anywhere in the world. We had visions at this point that the firm would provide decision guidance for end of life care decisions, as I had come so close to death and learned so much in the process. It was at this point that I fully understood my physician brain had been joined to a patient's heart.

Three weeks after retiring from the Cleveland Clinic in 2015, I made my way to Hayward, Wisconsin and began growing Curadux as a living entity. We've morphed the firm since our original soft roll-out and have found our place in helping individuals and families as beneficiaries of self-insured organizations navigate our fragmented healthcare system. We help the organizations become employers of choice, while lowering their self-insured expenses, and

allowing our members access to wise physician guidance on their schedule.

### **Recommended Blogs**

“How did Curadux come to exist?”, September 23, 2015.

“What is Curadux and why is it needed?”, September 30, 2015.

“Advanced illness or end of life services as a benefit retention tool,” July 13, 2016.

The logo for Curadux features the word "curadux" in a dark blue, lowercase, sans-serif font. A thin, dark blue arc is positioned above the letters "a" and "d", starting under the "a" and ending under the "d".