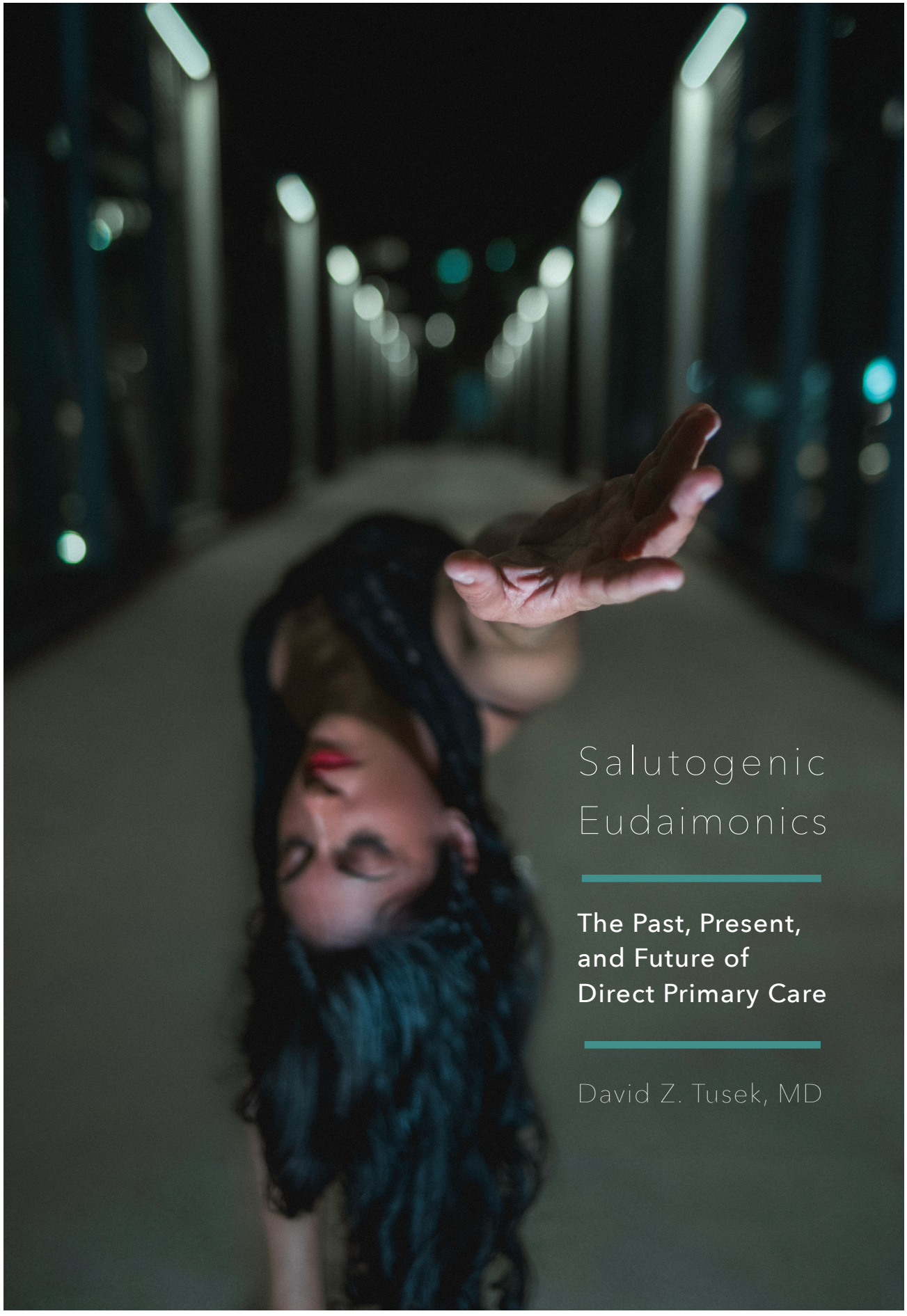

Salutogenic Eudaimonics

The Past, Present, and Future of Direct Primary Care

David Z. Tusek, MD

Salutogenesis

Salus (health), **genesis** (the origin of, to be born)

Salutogenesis: the sources and origins of health, and the pathways of supporting and nurturing healing. A medical approach focusing on factors that support human health and well-being, rather than on factors that cause disease (pathogenesis). The word salutogenesis was coined by Aaron Antonovsky.

Eudaimonics

Eu (good), **daimon** (demon, spirit)

From Eudaimonia, a Greek word commonly translated as happiness or welfare; or pertaining to "human flourishing or prosperity". Used as the term for the highest human good, and so it is the aim of practical philosophy, including ethics and political philosophy, to consider (and also experience) what it really is, and how it can be achieved.

It is no longer a fanciful abstract notion to aspire to a healthcare model that costs half of the cheapest conventional health insurance plan while offering twice as much value.

It is now a fully operational system with a proof of concept and track record of several years.

Today. Right now. In this time and at this moment, we have everything we need for every American citizen to have a personal physician on speed dial. Every one of us who wants this can have such a relationship. In fact it is the most efficient and effective path towards the healing of the US healthcare system.

Our fully operational model is both practical and pragmatic, and scaling it is a question of strategically re-aligning incentives toward the most important goal of any healthcare system: the wellbeing and best interests of our patients.

First and foremost the model involves repositioning the insurance industry into its appropriate place: protection against catastrophic illness, and removing insurance from where it is not needed—primary care. Insurance coverage for primary care is not useful and only does unnecessary harm due to countless inefficiencies and conflicts of interest.

Scaling this new model and practicing in this way is not only the path to a more sane and ethical healthcare system (which everyone deserves), it is also how we save our profession from the disillusion and despair consuming so many physicians and members of the healthcare workforce. Deep down we all want what is best for our patients, yet we participate in a system which continuously makes this harder and harder to do.

But healthcare reform is only one of the many challenges that we will face in the coming decades. As I will argue, the concept of 'health and healing' itself will not only require more clear and precise definitions, but they must become the new north stars of our future societies, if we are to thrive as a species—or maybe even survive.

In the pages ahead, I will describe how a growing grassroots movement in primary care medicine may hold an important key to the first step along this path of multi-system healing. In addition, I will highlight 10 outdated features of our current healthcare paradigm which, led by primary care physicians, are beginning to shift our system from one solely based on pathogenesis (disease-focus and sick care) to one which also incorporates the priniciples salutogenesis (the support of health and healing).

And finally I will introduce a new healthcare marketplace that is helping to nurture and support eudaimonics—the concept of community-based wellbeing, resilience, and antifragility.

In these COVID-19 days, it's as difficult as ever to make sense of the world.

Are the pandemic, the global surge of protests against racial injustice, and the crisis of faith in many (if not all) of our established institutions inter-related in some way?

What message do we, the practitioners of the art and science of medicine, have for our fellow human beings in this time of great reflection and contemplation?

Will our understanding of the concepts of health, healing, and wellbeing help light our way as we move forward, down such uncertain and perilous paths into the future?

Will the instutitions that we've built in the name of health serve as centers of wisdom, reassurance, and guidance in such a time of great turbulence and confusion?

Will we clearly see and be able to articulate the ways in which our healthcare system itself is cracking beneath the weight of its own unsustainability, in synchrony with the inherent instability of so many of the other institutions, industries, and infrastructures which form the foundational pillars of our society?

Perhaps it is precisely the notion of health that is being called into question.

The only viable path forward for our communities, our society, and our civilization is to clarify what health actually is, and learn how to cultivate and nurture a state of health within all of the various aspects of life.

To be healthy is to thrive, flourish, and exist in a state of adaptive, anti-fragile wellbeing. The words health and healing are related to the concepts of being "whole" as well as to being "holy". This implies the importance of integrating various forms of fragmentation and separation, as well as reconnecting to the sacred.

Whether we are able to collectively understand these integrations and connections or not may be the defining question of our time, and may in fact be an existential one.

I am a family practice doctor working on community-based resilience and health in Boulder, CO. I have a background in many areas of the American healthcare system. Originally starting down the path of becoming a transplant surgeon, I later changed course to train in primary care. Since earning my MD in 1999, I've worked for two decades as a board-certified family doc, and many of those included being an ER physician. I've staffed hospitals, nursing homes, college health centers, and many outpatient clinics. I've also had the privilege to live in 8 different countries in Europe and the Middle East.

So this patchworked background has unlocked within me a passion for the broader conversation around health, systemic healthcare, and the concept of healing writ large.

I am continually awestruck by the astonishing power of our western allopathic model to fix people who are broken in a certain way which cannot be denied. The modern medical miracle is a real thing and many have benefited from the vast toolbox of drugs and surgery with remarkable success and relief of suffering. From antibiotics to biologics, from immunotherapies to gene therapies, from liver transplants to total hip replacements.

And yet, it is a toolbox designed for Pandora. Something is terribly wrong.

The system is so complicated that it's not easy to figure out what is and isn't actually working. One important orienting step is to look at ALL of the various simultaneous pandemics of our time, not just Covid-19, as they clearly point to areas in which our current healthcare system is inadequate:

In addition to having lost 200,000 lives to coronavirus in the US at the time of this writing, we are in the midst of a ***pandemic of chronic disease*** including cancer, cardiovascular disease, and neurodegenerative disease—all of which are being driven by obesity. We are also facing a ***pandemic of addiction*** in which every 7 minutes someone dies of opiate overdose in the US (not counting any other drugs of abuse or alcohol). Additionally a ***pandemic of autoimmunity and allergies*** continues to escalate in incidence, along with other environmental illnesses caused by pollutants and endocrine disrupting toxins. We are also suffering from a pandemic that some have described as a ***"crisis of meaning"*** with an alarming increase in rates of suicide, depression, and anxiety. Meanwhile all of these pandemics are coinciding with the first documented successive two year ***decline in life expenctancy*** since World War I.

These multi-dimensional health crises are unfolding amidst a healthcare system so staggeringly expensive that it already eclipses the *entire* federal budget in terms of cost. In 2019 the budget of the federal treasury totaled $3.4 Trillion, wheras healthcare spending exceeded $3.7 Trillion, and those expenditures only continue to grow. By no later than 2027, healthcare spending is projected to exceed $6 Trillion, and by 2030, the annual cost of care for seniors over age 65 *alone* is projected to reach $3 Trillion. The math doesn't add up, especially as we face the prospect of plummeting tax revenues due to the record numbers of business closures and skyrocketing unemployment due to Covid-19.

And much like our systems of education, criminal justice, agriculture, energy production, the media, and infinite-growth based economics in general, etc., even a 5 year time horizon appears unsustainable for these and many other basic institutions without some kind of major overhaul.

To complicate matters, we are at an inflection point of profound uncertainty regarding the impending impact of three concurrent exponential technologies:

AI (Infotech)
Automation (Robotech)
Synthetic Biology (Biotech)

Each of them has the power to completely transform life as we know it very quickly, and yet there is little evidence that we are well-prepared for the various potential outcomes.

We are also facing the unpredictable threats of climate change-induced destabilization of food production and distribution, human migration patterns, and the lives of the billions of people living in coastal communities. And many experts warn about our national and international vulnerabilities to cyber attacks, power grid failures, and threats to our clean water supplies. Such threats continue to mount through the destruction of ecosystems leading to the decimation of forests, coral reefs, fish populations, pollinators, etc., to the degree that we are witnessing the rapidly accelerating extinctions of entire species which some have calculated to be 10,000x higher than the natural rate.

Related to this decimation is the toxification of our air, water, and soil which is now so pervasive that the pesticide glyphosate (the active chemical in RoundUp), the use of which has been growing logarithmically since 1990, is now present in human breast milk, in honey, and even in the rain. And most large ocean fish contain toxic levels of mercury, 10 million tons of which we dump into our rivers and oceans each year. Newborn babies have detectable levels of 200 chemicals which have been found consistently (almost universally) on day one of life.

Lastly, we are no longer able to ignore or mollify the core wound of our nation, implicit within its founding history. The profound collective trauma inflicted by our legacy of slavery and ongoing evidence of racism—as well as the genocide and deracination of the indigenous people of North America—continues to haunt us with increasingly painful reminders that this wound has not healed. Far from it.

Any of these challenges would be herculean in times of great harmony and collective solidarity. Unfortunately they are all coverging simultaneously, and we happen to be living in the most polarized society of the modern era, by most indicators. Our very systems of communication and media are intentionally algorithmically designed to foment outrage, indignation, and vilification of others.

It's fair to say we have a healthcare crisis in our country and we're clearly struggling to figure out exactly what's going on with the system and how best to fix it. But the answers to both of those questions—both what is wrong and what should or could be done about it—arise from and are interwoven with ***the deeper challenges that we face as humans on a global scale, on a species level, and as a planetary civilization.***

And yet there is hope. There is potential that by finding systemic solutions to the healthcare crisis, with all of its complex interwoven challenges, we may in fact discover essential insights for addressing the other concurrent crises in the rest of the foundational pillars of our society. And although most of our institutions will require coordinated and simultaneous re-envisioning, ***the alignment of our healthcare system towards a new north star could become a catalytic event which aids the others toward effective transformation.***

But what can be done?
What should we do?
How can we heal on all of these levels?
Where do we start?
Where is the new north star?

Here we propose the concept of ***Salutogenic Eudaimonics*** as a potential north star. This thesis rests on the notion that a deeper understanding of health, healing, and human wellbeing and the alignment of our institutions toward their support is the essential first step toward co-creating a future worth building and through which we will gain the necessary insights to address the other systemic issues. This is the path toward a future in which we are resilient and antifragile and can become worthy ancestors of our children's children.

The messsage we all need to hear this this: We *already* have *everything* we need to build the most beautiful world which our hearts know is possible (to use Charles Eisenstein's phrase). The next move is simply to see it. To see it with refreshed eyes that can constellate the stars that are already shining brightly, and bring them together into a more coherent and interconnected framework or network– a frame/net that, like most good ideas, doesn't just come from ordinary thought at all, but from a much deeper place–a realm of openness and willingness to receive. To receive and breathe in. To accept insight and inspiration with gratitude, recognizing that it doesn't just come from the conventional place of cognating or mentating that we use to analyze a math problem. It incorportates multiple forms of intelligence: concentration, contemplation, and meditation. It comes from:

A place where siloed information does not exist.
A place where the future can be remembered.
A place that can only be entered by saying:
"I don't know, but we know".

There is a new world view that is gaining the momentum of inevitability. It is fundamentally non-utopian, non-naïve, and non-pollyannaish. It radiates both sincerity as well as levity, with both science and spirit. It goes by many names and has various cultura foci and nuances. Some call it "2nd Tier", or "Integral", or "Metamodern", or "Post-Progressive", or "Game B". Others speak of the coming "age of the Eagle and the Condor".

This emerging world view develops its source code by clearly seeing the dark sides of the three dominant existing structures as mere variations on an ***"Us -vs- Them"*** ethos that must be transcended, while also acknowledging the deep-seeded value of each of those current perspectives. It looks backwards with gratitude and forgiveness, and looks ahead with openness and hope. It simultaneously embodies both grief and praise.

This perspective has not yet reached a tipping point in our culture, but it is gaining traction. It sees both the dignity as well as the disaster of the current mainstream views: conservative, modern, and postmodern.

The conservative (pre-modern) view contains a dark side which retains its ethnocentric heritage. It proclaims, "my country, right or wrong!", and "you're either with us or against us!". It leans toward xenophobia, homophobia, sexism, and racism, and not only carries a nationalistic tendency of ***"Us -vs- Them"*** but also an extractive, dominating mindset of ***"Us -vs- Nature"***.

The neo-con (modern) view moves beyond targeting specific populations of "Others" (an enormously positive evolutionary leap), but its dark side drifts toward a contracted ***"Me against The World"*** stance of hyperindividualism, narcissism, and corporate materialism. Its poster child is Gordon Gecko from the 1980's movie *Wall Street* whose motto was "Greed is good". Margaret Thatcher also articulated this perspective during a speech in 1987 when she famously stated that "there is no such thing as society, only individuals and families".

The progressive (postmodern) view attempts to embrace everyone's "truth" as being equally valid, but quickly backfires upon itself when it vigorously "cancels" those who disagree with their values, especially conservative and modernist individuals, and particularly if they're white males. Its dark side holds deep resentment and aversion towards most of the Western, Euro-American socio-cultural enterprise, even its many redeeming attributes. It is often expressed as ***"Us -vs- the Unwoke"***.

All three of these conventional existing ***"Us vs Them"*** world views are embattled and locked in bitter and immovable conflict on the political stage, yet each has extremely valuable contributions for our culture. It is paramount to honor, include, and incorporate their many positive and useful components. But this trifecta of opposition has brought us to an impass, and we cannot address our contemporary challenges with their frameworks, structures, and perspectives. All three are stuck in a war mindset which can only propagate further conflict.

The new cultural dynamics which are emerging arise from the stark recognition which is resonant with the principles of salutogenic eudaimonics. In fact, it is the most salutogenic eudaimonic epiphany of all:

There is no Them. There is only Us.

On a microscopic level, when we declare war on pathogenic microbes with broad spectrum antibiotics, we often unwittingly damage our own gut flora with potentially devastating consequences to our biology. An astounding 90% of all of the DNA in our body is not human. The vast repository of evolutionary intelligence within our "selves" is in fact neither homo sapiens, mammalian, nor even eukaryotic. It is our microbiome.

On the most fundamental level, we are not separate from the most primordial life forms which first appeared over 3 billion years ago. And they are inseparable from us. These organisms have co-evolved and co-exist interdependently with "us".

Even as individuals, we are superorgansims. And while germ theory and the era of antibiotics led to the development of a vast armamentarium of life-saving pharmacotherapies for acute infections, we are now realizing the serious downside of antibiotic resistance and potential unintended consequences of antibiotic overuse in humans as well as in animals. Similarly our declared war on insects has decimated our pollinators causing harm to our ecosystem. When we declare war on weeds we poison our soil and water and damage our bodies.

And on a macro level, when we fail to see that we are in fact a global society that is fundamentally interconnected – wired together with a shared internet-based neural network, we may miss seeing the wisest way forward amidst the mounting dangers of various geopolitical flashpoints.

Ours is the struggle to see the water that we are swimming in, to see our frames, and our own social conditioning. It is the struggle to recognize our inherent hard-wired ethnocentrism, narcissism, and revenge-seeking (which lead to separation and disconnection) and acknowledge the trauma-perpetuating characteristics of these universal human tendencies. It is the struggle to reach the escape velocity of the ego's orbit, both as individuals as well as groups. To move beyond that vestigeal aspect of our being which still dominates our lives but which is incompatible with happiness and wellbeing and is exclusively oriented toward rapidly cataloguing all of the ways that every moment of our existence is inadequate, unsatisfactory, or wrong.

Fortunately we have various maps, guideposts, and heuristics by which to reset our compass. Some of the key tenets of this newly coalescing world view include:

1. The biomimicry of natural patterns for regenerative sustainabiilty and resilience
2. An increasing ability of letting go of the need to be right
3. A willingness and desire for open source information
4. A deep interest in downstream consequences of our actions and innovations
5. A lack of conflict between honoring the innate worth and dignity of every human being, while recognizing the inherent hierarchy of values, ideas, systems, methods, and processes.
6. An increasing sense of comfort with paradox, duality, multiperspectivism, and multidisciplinary approaches.
7. Locally-based, decentralized networks—where-ever possible.
8. "Collaborate not Commiserate", and "Collective Intelligence not Groupthink"
9. A world-centric circle of deep care and curiosity.
10. A Focus on adult development and conscious evolution of the self first, and society second.

A move toward these core principles effortlessly recognizes the value of diversity—which is simultaneously both a celebration of uniqueness and a radical awareness of oneness.

We live in a time between worlds, or it seems that way for many of us. What this means is that, while it is difficult to put one's finger on it, there is a nonlinear shift that seems to be underway which is neither gradual, linear, nor merely a progression of business as usual, but rather a wholesale reconsideration of very basis of our usual business.

It very much feels like the story, the narrative, the agreed upon social contract within our culture no longer fits or in some ways no longer feels relevant, and needs to be updated in some kind of basic or fundamental way. A phase-shift is needed and indeed seems to already be underway.

Since earning my medical degree and pledging to uphold the code of the Hippocratic Oath in 1999, I have been flooded, flayed, buffeted, and gobsmacked by a sequence of events involving the patients who had entrusted their care to me. I call them my existential crises. They marked a series of awakenings to various intrinsic aspects of the system that I had become a part of, like a cog in a wheel, but which I found to be irreconcileable. These aspects simply could not be excused away or justified. They initially had a mind-numbing effect upon me. Eventually they broke my heart, just as I believe similar events and observations break the hearts of so many caring, dedicated, passionate human beings who enter our profession with bright eyes—only to become disillusioned, dispirited, demoralized, and jaded practitioners of modern medicine.

In ever increasing numbers, more and more of us bear witness to the great unacknowledged grief of our profession. As in most cases, the grief moves through us in the stages that Elizabether Kubler-Ross so neatly lays out in her work. The initial stages are marked by disbelief and denial. Then we move through anger, which eventually turns into a deep sadness, and finally (as we begin to heal) acceptance and integration of the grief which empowers and enables us to move forward again. I believe many of us in the medical field are currently stuck somewhere in the middle—alternating between disorientation, infuriation, and despair.

Martín Prechtel wisely teaches us that "grief" is just another name for "praise", and that our heartbreak is an indication of how much we care deep down, of how much we love. The grief we accumulate by working and participating in a system that is both wonderous and unjust, both miraculous and insane, both relieving of suffering and itself so causative of suffering ***is commensurate with our capacity to imagine a better system and to believe (to the core of our being) that such a system is possible***.

When we are able to embody our praise, to sing and laugh and yell with gratitude for all of the blessings in our lives—for the gift of simply *being* alive—we can learn to accept our own failings, our human limitations, our vulnerabilities and mistakes, as well as those of our parents, ancestors, and culture. From such an energetic state of appreciation and forgiveness, we can transmute our present and very real grief into newly discovered capacities and aptitudes which may give rise to unexpected insights, and possibly (with a lot of luck, good timing, and grace) lead to transformational action.

In my own experience, I feel as though my grief and heartbreak caused my heart to actually break open to new possibilities. From the 10 heartbreaks came the 10 core principles of our practice, Cloud Medical.

In 2009 I was fortunate to receive an inspiration that came to me in a dream. I was working an ER shift in a small Colorado mountain town, after which I walked back to the apartment where I was staying and I found myself pondering how many of the patients I'd just treated in the expensive hospital-based emergency setting I could have safely and effectively cared for from my clinic. At least half no doubt, I figured, maybe even 75%. Many came for lacerations and minor fractures, pneumonia and pelvic infections, migraines that wouldn't break with over the counter medications, asthma attacks and panic attacks, acutely swollen knees or elbows—all conditions that we are well-trained to handle reliably and responsibly in the outpatient setting.

So why did all of them end up in the emergency room, with all of its massive overhead expenses? The only reason these folks came to the ER was because they couldn't get in with their personal physician, or more likely as I discovered, they didn't have one.

I entered a few keywords into the web browser that night and came across a study which found that up to 76% of ER visits (in some communities) were for healthcare conditions which fall within the scope of outpatient primary care medicine. That night I had a dream, and the next morning I furiously typed out a detailed plan for a new kind of primary care practice based on membership model devoted to a reimagined doctor-patient relationship.

The core value and founding principle of this new model was for doctors to become the personal advocates of wellbeing and thriving for our patients, first and foremost. As primary care physicians, we would become unwaveringly loyal superheavyweight champions devoted to our patients' health. We would get to know them deeply as individuals over the course of longterm relationships built upon trust, reliability, dependability, and genuine care which would grow stronger over time.

Most importantly, we would be there when they needed us. Unlike the patients that came to see me in the ER in the days prior, those enrolled in our new model would only ever use emergency departments for life-threatening conditions like stroke, major trauma, heart attacks, and surgical emergencies. We would shield them from spending long hours in the waiting rooms of busy ER's where they'd be exposed to dangerous microbes, and spare them from the inevitable four or five digit ER bill.

And at the same time, unlike the existing "concierge medicine" trend, we would also become overall stewards of our patients' pocketbooks to ensure not only optimized *risk/benefit ratios* (in terms of health outcomes), but also optimized *cost/benefit ratios* (in terms of dollars spent).

In many ways it sounds odd that this was a novel approach or that such core values are not already part of the existing status quo, but the truth is that the insurance-based model of contemporary healthcare has insidiously carried us further and further away from this simple and obvious ethos.

The current "medical industrial complex" creates an endless series of feedback loops and vicious cycles which stand in opposition to our patients' best interests. And we physicians and other healthcare providers are hobbled by an endless, arcane, and often paralyzing bureaucratic morass of rules and administrative burdens which have been gradually sucking the life out of the doctor-patient relationship, leaving less and less time for the one thing that has real value—the human connection that enables an encounter to be meaningful, rather than merely transactional (or even worse—*extractive*).

Independent physician-owned clinics are becoming a rare breed because of the cadre of adminstrative "billing specialists" and "coding experts" required to navigate the ever-changing insurance landscape sufficiently to remain financially solvent. It's a Catch-22. Most small practices cannot afford to hire those additional employees, but without them they cannot recoup enough revenue to survive.

Furthermore, as doctors, we have no authority to dictate or determine whether a certain diagnostic or therapeutic intervention or service is actually "covered", at what percentage, or at what cost the particular service is "contracted" by the insurance company. Cash pay rates are different from Medicare rates which are different from Medicaid rates which are vastly different from rates negotiated by each and every unique health insurance plan. The same test or service can have dozens of different fees depending on which "payor" is used. We get caught in the gears of the maddening machinery, while our patients (with good reason) expect us to be experts in maneuvering through the paper-shuffling. "Surely my doctor knows the details of how my insurance plan works. Right?"

But there are countless plans from each of the many insurance companies operating in each state and they all have different permutations of coverage for each test, scan, procedure, medication, or modality. Furthermore, there are wide ranges in deductibles, and many who carry health insurance policies are effectively uninsured because they cannot afford their deductible (which these days is usually many thousands of dollars). Many of us do our best to help our patients only to find that 1.) there is no end to onerous rules and regulations, that b.) it would take a full time job to jump through all of the redundant, exasperating hoops, and that c.) in the end, insurance companies are not incentivized to care about our patients whatsoever.

But by sidestepping insurance altogether, we quickly realize that if you know how to navigate through the system (i.e. if you have the credentials to peer behind the Wizard of Oz screen of healthcare) you can successfully demand to know the cost of goods and services in the healthcare marketplace. Although many players in the industry still would prefer to conceal costs, an "MD" behind our name grants us access to the fee schedule at nearly any diagnostic imaging facility, lab, pharmacy wholesaler, and so on—as long as we ask firmly enough.

The most remarkable discovery has been that the vast majority of healthcare services that do not require hospital-based care are quite affordable without any insurance at all.

The fanciest and most detailed lab tests, the most high-resolution MRI scans, imaging tools to detect structural heart problems or detailed measurements of plaque, cancer gene analysis, etc…are all available for a few hundred dollars or less. Yet if you use an insurance plan that costs thousands of dollars a month you may still find that with a 20% deductible, you end up paying much more for a drug, blood test, or a scan than you would if your simply paid cash. That's because insurance rates are massively inflated far above the "real cost of goods and services".

Most MRI's, CT scans, and Echocardiograms still cost many thousands of dollars. Our local hospital bills $5000 for Echos and nearly as much for MRI's. We have negotiated cash rates with local imaging companies that perform our Echos for $200 and MRI's for $450. A 3-view xray series with our local imaging partners costs $60, yet at the hospital or ER it will cost more than 10 times more.

On September 5, 2020 ProPublica published the story of Dr. Zachary Sussman, a physician who works for an ER chain in Austin who went in for a SARS Cov-2 antibody test—the very same test that Cloud Medical offered to all of our patient-members for a wholesale cost of $20 in the early days of the Covid-19 pandemic. Sussman's insurance was billed for—and covered—the entire amount that was charged. What was the charge? $10,984. This is a mark-up of over 500X the true cost of the test.

This kind of graft is so widespread it is nearly universal albeit not always on such an egregious scale. There are many behind the scenes players who quietly turn massive profits while hiding behind extraordinarily confusing "EOBs", billing codes, and insurance claims. And they are only able to thrive due to the vast lack of transparency that is pervasive in our healthcare system.

This is the topic of many books and articles including Steven Brill's Time Magazine 2013 cover story "*Bitter Pill: Why Medical Bills are Killing Us,*" which highlights the fact that a single Tylenol capsule costs $50 in the hospital, and *"The Real Costs of American Healthcare"* by David Goldhill. The wizard of Oz screen contributes to the exponential rise of healthcare costs and premiums. It is devastating to our healthcare system, to our economy, and to the entire fabric of our society. If someone is getting paid $10,000 for a $20 test, then someone else is stuck with the tab. And that someone is either the patient him/herself, the patient's employer, or the taxpayer. All of this is completely avoidable and unnecessary.

Our newly designed model takes down the screen and sheds light on the real costs of healthcare. It also sheds the restrictive burdens of the insurance companies, and contracts directly with our patients. We provide full-stack primary care with no deductibles, no barriers, no "middle men", no co-pays, no "prior authorizations" (the interminable process by which physicians must attempt to convince low-ranking insurance employees with emails, phone calls, letters, and faxes explaining why a service, procedure, or test is needed), no prohibition on combining services in a single visit (e.g. a mole removal during the same visit as a PAP smear)…and so on.

One of our core values is to be stewards of our patients' healthcare spend by knowing the true cost of every single diagnostic and therapeutic modality so that we can quickly create a

reliable network of resources providing the services our patients needed (including labs, tests, x-rays, MRIs, medications, supplements, etc.) in our local community.

If our patient needs xrays, they can be done immediately for $60. If our patient wakes up in the middle of the night with severe nausea and vomiting leading to dehydration, we can arrange an in-home IV fluid infusion for $125 and keep them out of the ER. If our patient needs an echocardiogram we can do it at our office for $200. And the vast armementarium of generic pharmacological drugs is available for $10 - $20 per month.

No insurance is needed for this.

Primary care includes pediatrics, gynecology, adult medicine, office based surgeries, and urgent care. When practiced within it's full scope, it encompasses such a wide swath of services for such a large portion of conditions and medical needs that some estimates suggest that 90% of all healthcare encounters fall under it's umbrella.

In the outdated conventional model, however, physicians are incentivized to ***not*** practice within our full scope. Primary care physicians "earn" nearly as much revenue for a 7 minute visit consisting of refilling prescriptions as we do for a 45 minute visit consisting of a complicated skin cancer removal—with far fewer billing, accounting, documentation, and reimbursement hassels. So most primary care physicians practicing insurance-based medicine refer nearly all procedures to specialists who charge 5-10x for the same service and, instead of using the skills we trained so long to develop, ram several quick and easy refill visits into the same time slot. I know, because I was pressured to practice that way for years.

Our new model would reclaim the full role of the primary care physician, radically decrease unnecessary ER visits, and provide access and assurance to our patients "***independent of time and space"***: no matter where they are on the planet, and no matter what time it is, we always would be trusted, available, and accessible healthcare guides.

In 2010 we launched a rudimentary version of our model, the first of its kind in Colorado and one of the first in the country, although I was not aware of the other upstarts at the time. About a year later, I became aware of a small group of other innovators who had built practices around similar principles and in 2012 began regularly meeting in Washington DC at the Capitol Hill offices of Jay Keese (a healthcare policy expert specializing in innovative payment models) flying in several times annually to compare notes, share stories about our successes and failures, and begin developing (and lobbying for) political strategies to enable our budding, and still un-named, model to surmount various legislative hurdles.

By far the most significant of these was spearheaded by Dr. Garrison Bliss and Keese, prior to the formation of our small think tank, which placed a key provision into the language of the Affordable Care Act of 2010 (Obamacare) and gave our new model legal viability. Dr. Bliss deserves great credit as the earliest pioneer of our movement. Not only is he considered to be its "founding father", he had the prescience and determination to almost singlehandedly campaign for the insertion of a crucial amendment into the ACA legislation without which our model would have been deemed unlawful. I honor Dr. Bliss both for his trailblazing work and historic leadership, but also for his kindness, generosity, and humility in every one of our many personal interactions.

By 2013, our small quorum finally selected a name for our cause. It was admittedly clunky and imperfect, but it carried the spirit of our fledgeling movement better than any other moniker we could agree upon. We decided to call our model ***"Direct Primary Care" (DPC).*** And by the end of 2014 I, along with a dozen or so of my colleagues (with the expert guidance of Jay Keese), had spoken to countless Senators and Congressmen and women and their staffers, projected videos of our patients' testimonials on 30 ft screens in the massive subterranean meeting rooms on Capitol Hill, and were eventually invited to present our vision at the White House to president Obama's health care task force.

Although there continue to be various policies and IRS codes which create certain restrictions, particularly for Medicare and Medicaid eligible patients as well as enrollees of HSA plans, DPC enjoys broad based bipartisan support, and remarkably, there are now over 1300 established DPC practices nationwide.

The key tenets of DPC are:

1. ***A direct contract between patient and physician, rather than through an intermediary (i.e. insurance company) for a wide-spectrum of primary care services.***
2. ***Unparalleled connectivity, generally on a 24/7 basis, via cell, text, email, or office visit.***
3. ***Same day appointments for urgent matters.***
4. ***A low-cost monthly membership (typically approximately $80 per member per month).***
5. ***No co-pays.***
6. ***Focus on patient advocacy and cost savings (identifying the most economical sources of diagnostics and therapeutics available for patient-members)***
7. ***Primary care which is unbundled from insurance, as well as employer-based plans. Job changes are irrelevant to the established doctor-patient relationships.***

In 2016 I sold the original DPC practice that I'd founded and launched Cloud Medical with three locations in Boulder county and the aspiration of further developing and evolving its foundational tenets into a fully integrated healthcare model. What I came to realize is that DPC is potentially the most significant innovation of healthcare reform within my lifetime as a practicing physician. But it is only a first step.

DPC has the power to create the most meaningful positive transformation of the US healthcare system in recent history: ***The disentanglement of primary care from the behemoth that is the medical industrial complex.*** And in doing so, DPC could begin to set the trajectory towards a systemic re-alignment of goals, values, and principles which are health-generating and go far beyond the existing sick-care model.

For primary care physicians—those of us that do not specialize in a single organ or a specific body part, but rather who specialize in the whole human being—for us to become enabled and empowered to pledge our allegience to the best interests of our patients is a remarkable leap forward.

For our field of primary care, with the 220,000 physicians within our ranks, to be able to set aside the influence of insurance companies and pharmaceutical companies, to be able to find sustainable alternatives to becoming mere robot-employees of mega-medical systems, and to be able to become personally devoted health care guides to our own panel of patients—this, I believe, is the surest first step of recovering the soul of American medicine as well as saving it from near term collapse.

Some parts of the healthcare system, particularly the tertiary care settings of hospitals, may well be improved through further centralization efforts, but primary care can only flourish from its local, decentralized, nimble, diversified roots which are embedded in communities. DPC is the primary care model that is best poised to facilitate these goals, but on its own it is insufficient to address and repair the various broken elements of an ailing healthcare system.

Cloud Medical (as well as Ravel) is our wholehearted attempt at an intellectually honest and fair assessment of what works well (and in many ways amazingly so!) in our current system as we strive to harness and bring forth the best we have to offer within it's current framework.

Simultaneously, this is a forthright endeavor to acknowledge the areas which still need improvement (or in some cases a complete overhaul). And to meet the failures, the shadows, and the brokenness of our system with a steady gaze.

I believe we must do both (because neither is sufficient on its own) with a devoted effort, in a pragmatic, practical, down to earth, matter of fact, common sense way. It is time to practice it, not just preach it—to build it, run it, and refine it. Prior efforts at healthcare reform have not adequately assessed and acknowledged where, how, and in what ways we're going wrong, nor have they addressed the source-causes of the systemic inadequacy and dysfunction. Thusfar our politician-led efforts (including the ACA) have focused on shuffling around who gets stuck with the ever-increasing medical bills rather than developing strategies designed to produce different outcomes.

After four years of the Cloud Medical experiment (and six years in my prior DPC program), we can look back on our practice as a case study. From Cloud Medical's origins we realized that the DPC concept only solves for a small (but incredibly important) subset of systemic problems, and have endeavored to bring other key players into collaborative partnerships, and we continue evolving our ideas and testing them in vivo.

While there are surely many other ways to itemize and catalogue the aspects of our current system which are working poorly. What follows is the basis of our philosophy at Cloud Medical which challenges the well-established doctrine of the US healthcare system in general, and primary care medicine in particular.

I summarize my personal understanding of the key problems—my ***"10 heartbreaks"***— which have become transmuted into the 10 core principles of Cloud Medical. I do not pretend to know what will work for others, but offer these 10 principles for consideration as they have been successfully incorporated into our small DPC practice in Colorado, and perhaps others may find them useful.

Ultimately we are all in this together and are co-invested in a healthy future for our children, their children, and our planet. We welcome critques in the spirit of continuous refinement. What resonates with me most is the idea of collective intelligence rather than group think. I believe we need less consensus panels and echo-chambers, and more micro-experiments, prototypes, and idea labs integrated into collaborative networks. I believe in the principle of *"I don't know, but **we** know"*. And I believe that it really is possible to *"remember the future"*.

The kind of future that I "remember" enjoys and benefits from a healthcare system which not only incorporates the 10 core principles summarized below (and which are described in more detail later), but which is also imbued with two central values that were originally present in the indigenous healing traditions, but which have become lost or discarded along the way. I believe that we can't move forward without bringing them back.

The 10 Heartbreaks		Cloud Medical Core Principles
1. The US healthcare system is the #1 cause of bankruptcy	PAYMENT	We must lead toward drastic reduction of our national healthcare costs. Direct Primary Care (DPC) is the most promising innovation capable of meaningfully bending down the cost curve. Combined with a healthshare, most individuals, families, and businesses can save approximately 50% on their total monthly healthcare spend. This model is available nationwide today.
2. The US healthcare system is the 3rd leading cause of death	PRACTICE	We must reorient from a purely pathogenic sick-care model based on synthetic pharmaceuticals and surgery as our only tools toward a model that incorporates salutogenic principles. The purely pathogenic model is FAR too dangerous. Functional integrative medicine and naturopathy are better at seeking "source causes" rather than bandaid approaches. A growing number of PCPs are being trainined in functional medicine by the IFM, A4M and similar organizations. This is an excellent start.
3. We allow, enable, and are complicit in rampant conflicts of Interest & perverse incentives	PROFIT	We must stop conflating "prescribing" with "selling". They are very different! DPC physicians receive adequate payment from their patients ($80 per member per month provides a more than reasonable salary) so that NO additional selling and marking up tests, supplements, drugs, or therapies for profit is necessary whatsoever. All such products and services can be provided at wholesale cost (All diagnostics, medications, and products are provided at net-zero profit). This keeps the karma clean.
4. We often withhold power from our patients	POWER	Our major goal should be, plainly stated, "patient empowerment". We must retire the pretentious and outdated paternalistic approach of "doctors know best". By getting to know our patients as human beings with their own values and aspirations, and embracing humility for how little we actually do know, we can help orient our care to support them on their own terms.
5. We often devalue and discount the innate healing capacity of our patients	POTENTIAL	Physicians who tell their patients that "they will never walk again" effectively "curse" their patients, similar to voodoo. They are imposing their own limited views which are not based on fact. This happens far too often and their are myriad examples (E.g. Lance Armstrong was initially told he would "never bike again" upon his testicular cancer diagnosis).
6. We often poorly rank risk/benefit and cost/ benefit ratios and discount various biases inherent in publications	PRECISION	There are certain interventions that have very high benefit at very low risk. But many of our drugs have marginally beneficial effects with significant potential for adverse ones. We must always advocate for our patients and help them select the safest and most cost-effective treatment options. If you believe that "we already practice that way", please read #1 & #2 above.
7. We tolerate a lack of systemic transparency	PERSPICUITY	The healthcare system operates behind a massive wizard of Oz screen. This is a key problem that enables bad behavior and fraud. We should never prescribe a test or a therapy without knowing the cost to the penny—and share this information freely.
8. Our patient privacy laws protect the wrong parties	PRIVACY	HIPAA may protect patient from snooping neighbors and passers-by, and while this is appropriate, there is no protection against insurance companies and governmental agencies. Doctors should help their patients shield sensitive data from such large entities. If sensitive data is to be shared, it should be anonymized, consensual, and the patient should be compensated.
9. We are far too beholden to special interests	PERSONAL FREEDOM	Most medical consensus panels are composed of "experts" who are paid large sums by pharmaceutical and other for-profit companies and many are employed by hospitals whose incentives may not line up with our patients' best interests. The independent direct primary care physician is the rare healthcare guide who is not beholden to or biased by special interests.
10. Our system is vampiric and the "healers" have lost faith in our own profession	PASSION FOR MEDICINE	When the "healers" are disillusioned, jaded, and have unexpressed heartbreaks about systemic dysfunctions (such as the ones noted above) the transmission to our patients can be neither salutogenic nor eudaimonic. We must be intellectually honest and define the true causes of why our profession is so broken. The politicians won't fix them because a.) they don't know how, and b.) they are too entangled with special interest groups. Who is left to lead the way toward a sane and ethical system if not us?

In medical school we are taught to maintain a psychological distance from our patients, and not get "too close" becausing caring too much may cause us to lose our scientific objectivity, and/or cause us to suffer too much in the event that our patient ends up having a bad outcome.

While there are aspects to this view which seem logical, I have come to see this as a terrible lie which is paradoxically responsible for much of the suffering of contemporary healthcare workers, never mind the recipients of our care. It is precisely by fostering and encouraging a deep human connection with our patients that a healing bond is established, which I believe our patients need and deserve. But it is not just patients who need deep and meaningful connection, as only through such relationships do we the physicians and healthcare providers find meaning in the long hours of our demanding work.

A similar warning of "maintaining safe distance" with clients is given to law students—to avoid becoming too invested in the outcome of defendants who may end up with harsh sentences in court in spite their lawyer's best efforts. This contrasts with the approach taken by Bryan Stephenson, the defense attorney from Alabama who has devoted his life to exonerating innocent death row prisoners and confronting abuse of the incarcerated and the mentally ill. He explains that, "You can't understand the most important things in life from a distance. You need to get close." Stephenson famously developed strong connections to those he defended, and came to love them and care for them as though they were his own family.

Perverse incentives, conflicts of interest, and hidden agendas abound in the practice of medicine. The antidote for this is human connection rather than the transactional relationships of the medical industrial complex.

The way back and the way forward that we seek is in the opposite direction of the anachronistic med school and law school dictums to avoid close relationships with those we serve. The path we seek is one of reclaiming the dignity, the decency, the heart-break-opening beauty of caring for another human being from the depths of our soul. Saying yes to the pain of bearing witness in deep empathy and solidarity to another person's suffering, precisely when we have exhausted all of the tools, techniques, and tricks of our trade, and when (after consulting colleagues who are experts and specialists in other areas of medicine) we have little more to offer than our presence—that too is the work of a healer.

As much sadness as this wells up in our hearts, it is a kind of sadness which is transmuted into unity, into connection, and into love. And this is ultimately the greatest, most potent, most universal healer of all. With infinite paradox, it heals us too. This connection heals the broken hearts of the wounded healers (which we all are). Indeed it is the only thing that can. It is telling that both the word "healing" and "love" are all but absent from mainstream healthcare. In fact they are generally considered taboo and gauche by the medical establishment.

The vanity and pretentious artifice of withholding our hearts and our caring in order to create a "safe distance" at an arm's length, in order to ostensibly build a protective barrier and buffer against our own ability to grieve along with our patients when illness progresses beyond our capacities of calling life back, this lies at the root of the sickness of our healthcare system. ***What is missing is not our emotionality, but our emotional intelligence.***

There is nothing too complex, esoteric, or mystical about this recalibration. It is simply the path of finding one's truest, deepest, most meaningful purpose and calling, one's life work, and realizing with a dawning ironic smile that this grand mission of ours was never about *"us"* in the first place. Rather, it is about our offering and our contribution to others, to those we serve, to our patients, to the world, to our children, to those who come after us.

To whom else or to what other cause ought we dedicate our professional lives?

In this devotion and dedication, and in this reverent and humble offering of our gift, we get our lives back. By way of this act we reclaim our souls, we rediscover our life-force, our competence, our unique gifts, our joy. These are the very attributes missing from the medical profession with its ranks of disillusioned, dejected, depressed, and jaded colleagues wondering why they invested so much of their lives to a career so hollowed out by the various self-serving promotors of false aims and false claims.

And so, it is time that we the physicians, providers, healthcare pratictioners heal ourselves. That is our main calling now. I believe we must heal ourselves of our complicity in a system and paradigm which is simultanously miraculous but also insidiously inhumane, insane, and unethical.

It is my belief that this healing can only come through rising up and joining together to disown the lie of distance and separateness from our patients and also to dispell the fantasy that it should somehow be the job and responsibility of politicians, administrators, industry leaders, and policymakers to show us the path to reform and lead us toward a system of healthcare that is more humane, more sane, and more ethical. How could they?

It is up to those of us who know what it is like to sit with a dying patient and their family as they take their final breath, or to look another human being in the eye and explain that their results indicate a serious diagnosis, or to hold someone's hand and reassure them that treatments and therapies exists to ameliorate their condition. It is we who are now called to step forward and speak.

We must speak clearly and precisely. We must discern the things we do that really matter from the mere distractions, the fundamental from the trivial, the essential from the marginal. These crucial distinctions often get conflated, manipulated, and obfuscated by forces which do not have the best interests of our patients in mind. And we can no longer afford to let this happen.

THANK YOU FOR READING. PART 2 OF THIS ESSAY WILL BE PUBLISHED IN Q4 OF 2020.