Making Medical Decisions
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Welcome to the 28th podcast for BioBalance Health. This is Dr. Kathy Maupin the Medical Director of BioBalance Health. And I'm here with Brett Newcomb who is a lecturer and counselor in the psychological field. Today we're going to address how to make a medical decision. If you're not a doctor or someone who has been trained to think like a doctor you might be get muddled up in all of the doctor speak and options and suggestions.

Brett Newcomb: It's easy to get lost in all that stuff when you don't know the terminology and you don't have the skill set. But there's a subtext message in this conversation today, and that is that it's important to make a decision. When you are hanging in limbo and you are experiencing anxiety and frustration and fear, you get the information you can get and then you pull the trigger, you make a decision.

KM: And one of the decisions you can make, there are options in decisions. A decision is to either follow your doctor's suggestion or to do nothing. Which is a decision.

BN: I talk to clients about that all the time. I talk about something called the cost benefit ratio of emotional economics. Because even to decide not to do something is a decision.

KM: And people don't think that. They think 'oh I'm not going to do anything so then I'm not making a decision yet'. When in fact they are.

BN: And so I don't have the responsibility.

KM: And they don't have the responsibility for the symptoms and for the problems that follow. So interestingly enough we had an email from our couple in Cleveland. A re-email. We've been having an ongoing conversation. And we've had enough transfer of knowledge between all of us that I suggested that they actually they make a decision. They've been given all the information by their doctors and by me kind of filling in the blanks. And now it's time to make a decision. But then I realized that it's not appropriate for me to tell them to make a decision if I don't tell them how. And many patients come in and they don't understand how to make a decision about their medical care. It's very emotional and the other side of their brain flips in. Their emotional part flips in and they don't hear another thing we say. So often times I write it down and even in my terrible handwriting they can still follow what I'm talking about and what the options are.

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BN: Sometimes it's an issue of terminology and so you need to be sure they understand the terms that you're using and how they react to those terms. People do, they numb out, they shut down, they hear a word like cancer and they say "oh my god, I'm going to die". And most people don't die from cancer. Most cancers are treatable and survivable but still the common response to a cancer question, not even a diagnosis, is "oh my god, I'm going to die."

KM: Right. And sometimes it feels like dying, if they think, if one spouse thinks that the other spouse isn't going to get "fixed" that kind of feels like dying as well. And then the emotional part kicks in and they can't make a logical decision. But to actually make a medical decision for yourself or for your spouse, you have to sit down and get the left side of your brain, (the right hand/left side) that's the logical part, and make a list of all the things you could do and what the side effects are of that. Because the process is basically, figure out the risks of doing nothing, figure out the risks of going forward with what the doctor ordered. And then there's always another option which is another decision you can make, another treatment plan that isn't as good, the outcome's not going to be as good. It's going to be the second choice and you're going to have to put up with other things. You're going to have to suffer with pain or suffer with emotional distress because you made the not so optimal choice. Now having said that, there's really no "good" choice in medicine. It's not going to be easy not matter what happens.

BN: Yes. And what's good, Kathy, is that you're not selling. Years ago when I was in the sales field they taught us something called the Ben Franklin close which is very similar to what you're talking about.

KM: I'm not selling.

BN: No you're not selling and that's the critical piece of information. The client has to make the decision that affects their quality of life, their pain, their cost, their survivability and it has to be their decision. Ethically, it has to be their decision. So good medicine is to say very clearly, here's all the information, here are all the facts, here are the protocols, these are the costs as we know them, now you have to decide what you are willing to do. And so that's when they move to the Ben Franklin close. The Ben Franklin close is, the story is, that whenever Ben Franklin had to make a major decision in his life he would get out a sheet of paper and divide it in half and he'd label one side pro and one side con. He'd put down all the reasons to do it and all the reasons not to do it. And then one would become obviously longer than the other. And that should lead you to a decision. The sales trick in that is that when you're helping a client or a prospect, (you know; "hello mister prospect"), make their list you only give them the information you want them to have. So your side is going to be so much longer. But a good doctor, good medical treatment, doesn't sell a response. They give information, they calm the client down, they help them focus on this is the data, these

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are the costs as we understand them, these are the potential benefits as we understand them, what is it you're willing to do as an individual or as a couple.

KM: That's why we have our website with all of our information with references to medical articles because basically I can't give every piece of information in 45 minutes or an hour. I can't go through everything. And, in my old life, when I was doing surgery and delivering babies and decision making there, we had like 15 minutes. It wasn't enough time. But if you took more time you'd go out of business. So, in any case we had that much time.

BN: So there's a balance. The balance is driven by integrity; the balance is driven by what it is that you're supposed to do. And in sales they, again selling. If you were selling treatments, if you were selling protocols, if you were selling, if you had to do 75 hysterectomies this month in order to pay the rent and so you were trying to find people to do them that would be so unethical.

KM: That doesn't happen in ethical practices. I don't even know how many you would have to do to, I don't even know that.

BN: No, and most doctors don't, and they don't focus on that end of their business because they're trying to do what you're talking about, which is help patients learn to make good medical decisions based on good medical information.

KM: I think my biggest issue, when I was convincing people that they needed to have surgery, and there was never a "you have to have surgery" unless it was cancer or something like that. Which was very infrequent.

BN: But even then it Is still a choice, they have to sign the release.

KM: That's right, they do, but that was, I had to give them the risk of not having treatment and that was usually devastating. And so there was much more on the side of doing surgery or medical treatment for the cancer than doing nothing which meant slow miserable death usually. In this case the risk of surgery was a lot less than the risk of keeping the cancer inside. When I'm talking about hormonal treatments the biggest risk for testosterone is facial hair for women. So that's really it, and maybe some oily skin or some acne. But we have ways to prevent those things; if somebody has that we counter act that with trouble shooting. This is one of those things that I usually go through the risks and benefits of both things. The biggest risk of estrogen treatment is vaginal bleeding. I have a lot less risk, I don't even have to talk about many risks with estrogen pellets because they don't have the same risk as oral estrogen. And so they don't cause breast cancer and they don't actually cause, they don't cause blood clots because it's just the same as having your ovary back. We're not high risk for blood clots.

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BN: And that's another useful piece of information about what makes the services you provide different from what other doctors do because they don't have that information about the distinction on different delivery mechanisms.

KM: Right, and you have to study that, you have to find all that information. It's in various journals in different fields. You can't just look in the OB journals and find any of that stuff. You have to look into journals that are endocrine or cardiology or rheumatology or any of those that actually discuss the replacement of testosterone and estradiol. But that's not the biggest problem. The problem is that when I give estrogen, when anyone gets estrogen in any form, then they have to take progesterone and their risk is they'll have vaginal bleeding.

BN: With Progesterone?

KM: Without it they'll get uterine cancer. With it, then they may get vaginal bleeding. But it's about 50/50 if you have a good, if you have enough estrogen your uterus thinks it's 35 again and it collects lining. We have to give enough progesterone in a natural form to counteract that and it doesn't always work. People often bleed because they have fibroids, they have pre-existing problems. Fibroids or cysts or a spongy soft uterus from having many pregnancies, that all gets reactivated.

BN: So when you've run the tests and done the analysis for a particular client in terms of their physiology, can you reduce it down to a percentage risk factor? You know there is a 70% chance of this for you or a 35% chance of this for you?

KM: Honestly, it's either there's a high risk or there's a low risk when we get down to numbers. I don't think numbers help. If it's you it's 100%.

BN: That's insightful. So you "worse case" it. What if? If we do this, this can happen to you. So what if it does? Can you live with that? How will that impact you? How will that affect your relationship?

KM: And that's how I usually talk about that. And that is an issue you can then go forward and have something done about. It's not forever. You can actually have a procedure. So the issue is, if you take any estrogen, if you need it, if you take any estrogen, then you may have vaginal bleeding if you have a uterus.

BN: One of the questions I always ask a physician when I have an opportunity to do so and they're giving me information about treatment protocols and risk factors; I ask them "would you do it? Would you do it if it was your wife, or your son?

KM: I think that's the best question to ask. And people ask me that all the time after I've laid everything out. Then there's always a way that I think is probably better for the patient. I mean I'm looking for a treatment that's going to relieve them of problems in their lives like having to deal with bleeding [into old age]. And having to actually be healthier. Because it's not healthy to have a thick lining. So if they don't take their

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progesterone they probably won't bleed for a long time, but they'll thicken the lining. So I have to stress what's absolutely . . .

BN: And that has its own health risks.

KM: Absolutely. The thickened lining can become uterine cancer. And that's not acceptable, it's not an acceptable risk. So I have to, I make sure everybody is taking their progesterone when they come in. If they don't want to take it, there are alternatives. One of those is getting an ultrasound every year or getting a DNC every year. Or an endometrial biopsy if they just can't take progesterone. There's always another option. But those options are surgery, risk of surgery, risk of pain with a procedure in the office like an endometrial biopsy. There's no perfect answer for this. And everybody thinks there's some perfect answer. Where they can just, I can just snap my finger and it's going to be gone.

BN: A magic answer.

KM: But the biggest, the closest I can get to the perfect answer for this particular issue, which is the biggest. I don't have a lot of other risk factors or issues in my practice now. But this is the one we spend the most time on.

BN: So every choice costs and every choice pays. And so when you're talking about the cost you're talking about the medical costs, the physical cost, the pain cost, the discomfort cost, the self image cost, and you're talking about the rewards. What are the self image rewards, what are the physical comfort rewards, what are the . . .

KM: What are the partner rewards? I mean in general it's a partner deal, if women don't have estrogen at all they have dry vaginas, painful intercourse.

BN: Which means they resist, they avoid.

KM: Who wouldn't, because it's painful.

BN: Exactly.

KM: It's not what It should be because they have what I call Old Lady Bottom. You know, it's just, it shrivels up without estrogen. But testosterone is an alternative because testosterone can then, if they just want testosterone alone, then that can actually bring the vagina back to normal so they won't have old lady bottom, they won't have the pain. But estrogen helps a little bit with some other feminizing things. It counteracts the facial hair and things like that. So I would much rather give a balanced hormone environment to someone and create that instead of creating something that is imbalanced. But, if their fear of surgery or a DNC, their fear of having any kind of office procedure. . .

BN: Their discomfort of bleeding.

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KM: But they're choosing bleeding if they chose not to do any of those either procedures. So all of those things are negative and you have to decide what you want to do. And that's the hard part. You have to decide what's acceptable to you. Some people are so fearful of surgery they will not have surgery unless they're dying unless they come in in a car accident. I can't take away 40 years of fear.

BN: So we're talking globally about anyone making a decision, making a medical decision. In terms of this couple, you were starting to say they have all the information that is known and available at this point. And what they need to do is sit down themselves and talk together honestly about what are the next steps. What are the costs, what are the rewards, what are they afraid of, and come to a decision and then go to their medical professional and say this is what we want done.

KM: Their biggest issue is fear of having something done or fear of bleeding. Or dislike of having bleeding or periods. Because you can make someone have a period each month on hormones if you do it right but they don't want to do that either. So is that fear of those two things worth not having a sex life?

BN: And what are the costs of not having a sex life.

KM: What are the costs of that for both people and for their partnership? That's the first step. If you can't make that decision, you know you have to make the decision to go one way or the other. Sacrifice something. And then you go to the next decision which is risk and benefits of the offered therapy. And one was like a Mirena IUD, you can put that into the uterus even after menopause and it has progesterone and it seems to stop bleeding and you don't have to take progesterone as a sublingual tablet. That works, it's been working in Europe for years, they've been putting it in at the same time as pellets. But we offer it and we send them to their gynecologist for it. I used to put them in all the time; it's a pretty simple procedure. But still it's a procedure and it's in the office. That's one option. Another option is, like I said, to have ultrasounds, and endometrial biopsies and cleaning out the uterus in the office or having a DNC and an oblation, where we burn out the lining. Those are all the things we offer or you can just do nothing. And then your choice is . .

BN: But doing nothing is a choice.

KM: That's a choice. And everyone has that choice. When they go to their doctor they don't have to do what the doctor says.

BN: And another choice that people can make if they interview doctors in their area, and those doctors are not informed ornot up to date on these protocols they can come to St. Louis.

KM: We have people come from all over the world to come see us and get treated. And they just seem to come to the United States two or three times a year. And we have them visit us to have pellets inserted. It's not a daily thing and usually we ask them to

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stay in town for a day to make sure they're okay because we have to make a little cut and the pellets put in the hip or in the love handles. In general we don't have any major complications, we have minor little infections or bruising or pain for a week, some pain but not terrible pain.

BN: So at the end of the day then the message for this couple and for other couples is do your research, do your homework, talk to each other, talk to your doctors. But at the point where you have done all of that, make a decision and live with the outcomes.

KM: That's right. You can always go back and change your mind.

BN: If you want to try the other outcomes.

KM: But especially if you've chosen to do nothing, you can go back to your doctor and say 'well I think I'm ready'. I think the first hurdle is jumping off that cliff into 'yes, I'm going to actually accept medical treatment to do something, stop this bleeding so I can have the hormones I need'.

BN: And to recognize you are proactively pursuing a choice even if the choice is to ignore that there is a choice.

KM: That's right. You know we talked about earlier the choice in terms of hormones. The reason I do pellets is that it's the safest method. It's the least likely for you to forget it because you have to just come in two to three times a year. You don't have to think about it every day so you're going to be compliant. And it's bio-identical so it's just like your own hormones. That's also safe, has fewer side effects than any other forms of estrogen and testosterone. There aren't very many other forms for women and the men's aren't usable for women because it has lots of side effects. The doctors themselves choose the optimal treatment, or they don't know what the optimal treatment is and just give you a choice and you have to research it. The choice is taking hormones and kind of backing up your aging process, looking and feeling better and actually being healthier. It really helps both men and women have healthier hearts, healthier cardiovascular systems. It also prevents Alzheimer's and prevents obesity, diabetes, and things like that because you get a more lean body in general when you have more testosterone. There are many benefits and then the risks are if you don't do anything, if you chose not to replace it, then the risks are Alzheimer's, diabetes, heart disease, and all of these, and osteoporosis. I mean there are so many things that hinge on those.

BN: Which are all survival related to the individual but there are also relationship risks. In terms of losing sexual intimacy.

KM: Losing your spouse. I mean often times this causes such a riff that it can't be repaired because the spouse sees it as, "if you would just do this".

BN: Right "You're rejecting me if don't take this risk".

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KM: But fear is a very big factor and they would have to be counseled on how to get past the fear.

BN: And if they have questions about that, where to get it, or how to get it they can look on the website.

KM: Biobalance.com

BN: Or the other website.

KM: DrKathyMaupin.com or they can call the office at 314-993-0963

BN: We would like to hear from you and you can reach us at the podcast, there is an email address. Kathy can you give that.

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