Under My Skin

Obsession

I was about to desiccate some small keratoses on Edwin's face. "Will this scar, Doctor? Will it leave a hole?"

"No, it won't scar or leave a hole."

"Will it leave a scar or a hole?"

"No. No scar or hole."

"Will it leave a scar or a hole?"

"No scar. No hole."

Obsessive patients present a challenge. It's hard to answer the same question over and over without being tempted to slug the questioner. This impulse, of course, should be resisted.

BY ALAN ROCKOFF, M.D.

Because of the kind of work we do, dermatologists encounter obsessive behavior rather often, whether or not it rises to the level of clinical OCD. Its roots can be the patient's anxiety, social role, or personal style.

Anxiety is a great promoter of obsession.

"This spot is changing. Is it cancer?"

"No, it isn't cancer."

"It's not cancer?"

"It's not cancer."

"Are you sure it's not cancer?"

By this point we may be wondering how sure we are, but we can't very well say, "Well, okay, maybe it is cancer," without losing a certain amount of credibility.

Then there is the social role, specifically the maternal one. Mothers feel that they are required to make sure no stone is left unturned, for fear that later one of the stones will turn out to have something under it. This leads to familiar family minidramas.

"Samantha, please take off your shoe and show the doctor your warts. Do you have some on the other foot, Samantha?"

"No, Ma, just on this one."

"Why not take off your other shoe, just to check."

"There aren't any on the other foot. I looked."

"We're at the doctor's. Let's take a look, to be sure."

"Ma!"

Some day Samantha will get her chance to pay this forward.

Then there is personal style. It's beyond my competence to decide which of these patients deserve the diagnostic label of OCD, just as I am unsure how many people who admit to washing their hands 10 or 15 times a day are more than just fastidious. In any case, obsessive style can show itself in list-making, whether of complaints or spots.

Our hearts sink, of course, at the sight of a meticulous list of concerns. "I wrote down my questions, Doctor, so I won't forget any."

Questions on lists are best addressed individually and in order. Any deviation means having to start over. ("Wait, did we do this one yet?") This is especially true when the list contains specific spots to look at. Each listed spot must be noted and addressed individually. Global evaluations will not do.

"It's on my back somewhere."

"Let's see. I'm looking at your whole back, and everything looks fine."

"But wait, it's here somewhere. …"

If the patient is sufficiently anxious or obsessional, I resort to what I call "the OCD three-step." I touch the spot, pause, and say:

"I'm looking at it. …I can see it. …And it's okay."

Only then may I move on to the next spot. Any change in sequence or cadence means having to start over. ("Wait, did you see it?")

Once they finger a spot, patients tend to fondle it lovingly—and at length—making it necessary to gently suggest that they move their opaque digit out of the way.

Sometimes, of course, my patients cannot find the thing that worries them, especially when it is on a hard-to-visualize area like the scalp. If there is something more maddening than watching someone palpate himself with increasingly desperate and furious futility, I don't know what it is.

When this happens, I politely excuse myself and leave the room, explaining that identifying the spot will be much easier when I'm not standing there making everyone nervous. Then I return a couple of minutes later to find the beaming patient with his index finger affixed to his noggin. "I found it!" he exclaims.

Ah, blessed relief.

Compared with our colleagues who may have to address complex medical issues, we have a pretty easy time of it overall. Dealing with obsessive behavior can be a challenge, but it's generally manageable as long as we don't get two or three such patients in a row. That circumstance calls for some form of tension relief, perhaps a glass of something or other after hours.

That's what I think, anyhow.

So what do you think?

So what do you think?

So what do you think? ■

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Continued from previous page

Earned," Letters, August 2008, p. 19).

Health care that needs to be earned? Our country was founded on the self-evident truths that all citizens are created equal and are endowed with certain unalienable rights. These have been declared or evolved to include rights to worship (dependent on clergy and religious hierarchies), to justice (dependent on our system of police, lawyers, and judges), and access to communication (dependent on a plethora of telephonic, postal, and media services), just to name a few.

In ours, the richest of all nations, why should health care be viewed differently?

Certainly it is within our capacity to recognize health care as a facet of life, liberty, and the pursuit of happiness, as do almost all other nations. That health services are the result of the collective efforts of the many caring individuals who choose to serve their fellow citizens is only the more ennobling. Our commitment is to serve all in need, not just those who can afford it. Our social and financial station still ranks high.

It would be immoral to deny services to those who, for want of better circumstances, cannot afford them. Sure, all citizens should contribute to a free society according to their ability, but in return they have the rights to the benefits of that society.

Health care is one of them.

Ronald Blum, M.D.
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Health Care Is Not a Commodity

Dr. Steven Kreisman argues that the assumption of health care as a "right" is a morally untenable premise that is responsible for the current quagmires of the American health care system ("Health Care Must Be Earned," Letters, August 2008, p. 19).

He also asserts that treating health care "like any commodity" will garner stability and success.

If only markets could be so simple.

In the United States, where the overall tax burden is comparably lower than more centralized economies, taxpayer projects promoting the common good are more acceptable than individually focused proposals. But the competitive edge that the United States once enjoyed has been blunted by increasing employer health care costs and a progressive disease burden with associated productivity declines. Health care needs to be considered as a common good.

Health care is unlike other commodities. No other industry encompasses the degree of information asymmetry, ethical complexity, and moral hazard inherent in medicine. Can you equate the choice of an antihypertensive to the purchase of orange juice?

Dr. Kreisman's argument reflects the anxiety that many physicians feel about a system of universal coverage. It's rooted in the fear of lower financial remuneration and a cynicism toward the ability of our government to serve the needs of the populace. As to the former, more insured patients assures a more consistent demand for health care and an associated stimulus for research funding. As to the latter, we must remind ourselves that Medicare is more streamlined and cost effective than the present assortment of insurance providers.

A basic level of "health care as a right" should be established independent of socioeconomic status. Then, a secondary market of "health care commodities" can be created and traded in an imperfect health care market.

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Uninsured Families Spend on Luxuries

I must respectfully disagree with Dr. Steffie Woolhandler and her opposition to consumer-directed health care ("Do High-Deductible Plans Coupled With HSAs Promote Underinsurance?" Point/Counterpoint, July 2008, p. 18).

She attempts to prove that universal single-payer coverage is necessary, but ultimately never attacks the real issue as to why people are underinsured: personal irresponsibility.

As a physician I can attest that where people place their spending priorities is a significant part of the problem. It is not uncommon to see families with $200-$400 cell phones, sneakers that cost as much as my suit, a nicer car than mine in the parking lot, and other luxuries, while carrying a Medicaid or Medicare card. Many also smoke at least a pack of cigarettes a day at a cost of over $3 a pack. This is money that should be spent toward health insurance and health costs.

All of the discussion regarding health care as a right provided by government has only increased individuals' refusal to take responsibility. Dr Woolhandler gives us a great example when discussing the Canadian situation. Individuals have devalued health care services so much, that it is not even worth a copay to see a doctor.

In the case of the truly hard-working poor and elderly who sacrifice and still cannot provide for themselves, I support government assistance, but only for that limited population. To do otherwise is to continue a trend of making individuals completely dependent on the government for everything. It is important for people to learn that they must be responsible for their own needs, even if it means sacrificing wants to meet those needs.

Keith VanCuran, M.D.
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Correction

In "High-Dose Interferon to Treat Melanoma Offers No Benefit" (July 2008, pg. 33), the accompanying graphic percentages should be 75.4% for arm 1 and 72.9% for arm 2.

Letters

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