Cards, Cakes, and Homegrown Tomatoes

Paul M. Fischer, MD
Augusta, Georgia

The year 1993 will be a pivotal one for medicine in the United States. Bill Clinton has promised quick action on the problems of health care cost and access. The changes are likely to be swift and imperfect. To date, most of the debate has narrowly focused on how the country can provide more medical technology, to more of the people, at a lower cost. There has been no articulation of the need to provide each American with a personal relationship with a primary care physician. Instead, physician care—usually referred to as "physician services"—has been viewed in this debate as a generic commodity that can be bought, sold, reallocated, or traded to the lowest bidder. In our attempt to provide CT scans for all, will we develop a system that ignores the central role of the human relationship in the fragile balance between health and disease? Will the doctor-patient relationship survive the health-care-crisis solution?

Shirley's Case

I met Shirley 5 years ago. She had been regularly seen at the Rheumatology Clinic during the previous 2 years with complaints of swelling and pain in her joints, especially those in her hands. Each of these visits had been accompanied by detailed history-taking by medical students and drawing of blood for many laboratory tests. These often repeated tests invariably resulted in the same conclusion at the next rheumatology visit: "Findings are suggestive of rheumatoid arthritis, but the patient's rheumatoid factor is negative."

By the time I met her, she had been forced to quit her job as a seamstress. She simply could no longer sew. She was 28, married, had two children, and a very large extended family, all of whom I was later to get to know. She had been referred to me by her friend, who was also my patient.

Her rheumatologic history had been accurately and extensively recorded. Not noted in the chart was the fact that she was a tough woman who had rarely missed a day of work before her hands started to swell and hurt. She could not understand why her problem had remained so perplexing and why no one had been able to help. I reached out and took her hand. Her PIP and MP joints were obviously swollen, hot and tender.

The diagnoses were obvious: (1) seronegative rheumatoid arthritis; (2) reliance on a test result rather than the patient's signs and symptoms; and (3) lack of continuity of care in a subspecialty clinic.

I shared the first of these three diagnoses with Shirley and asked her if she would be willing to try an experiment. We would treat her with prednisone for 7 days. If my hunch was right, we could confirm the diagnosis in a week without drawing a single tube of blood.

I knew the results when I walked into the room that next week. She had a wonderful, little-girl smile. She presented her hands like presents to me—no warmth and no swelling.

My experiment had secured a trust that would endure. Not that it has not been challenged. Shirley has since had gold-induced nephrotic syndrome, azothioprine-induced diarrhea, and NSAID-induced gastritis. But Shirley is doing very well on 10 mg of prednisone every other day. She is sewing again.

Shirley and I share what is euphemistically referred to as a "doctor-patient relationship." She agrees to let me experiment with her care. I agree to be there when she is sick. She agrees to take her medicines, even when she does not like the side effects. I agree to think about her "case" sometimes when I am driving to work in the morning. She agrees not to call me unless it is important. I agree to get right back in touch with her when she calls. She bakes me cakes. I eat them.

Paul M. Fischer is editor of The Journal of Family Practice *and professor, Department of Family Medicine, Medical College of Georgia, Augusta, Requests for reprints should be addressed to Paul M. Fischer, MD, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912.*

© 1993 Appleton & Lange
ISSN 0094-3509

Patients as Voters

I worry that the people involved in the political debate cannot answer for themselves the simple question, "Who is your doctor?" They seem all too eager to replace the personal relationship between patients and physicians with micromanaged, bureaucratic, and inflexible "programs." Efficiency will be gained by "managed competition." Overutilization will be eliminated by "clinical guidelines." Medical care will be organized around "health care systems," not patients and their doctors.

Family physicians have been rare voices in calling for attention to this issue. Dietrich showed that primary care physicians manage 75% of patient care in a fee-for-service setting.[1] Franks, Clancy, and Nutting[2] have identified the doctor-patient relationship as an essential element for avoiding unnecessary treatment. These are undoubtedly the reasons why family physicians have been shown to be more cost-efficient providers of care than other specialists.[3] Mold and Stein[4] have described the "cascade effect" that occurs when patients are cared for by "systems."[4] Brody[5] has eloquently argued that the doctor-patient relationship must be the basis for ethical decisions about a "good death" that avoids prolonged pain and suffering.

Each medical specialty has its own therapeutic technology. Gastroenterologists have their endoscopes. Gynecologists have their laparoscopes. Cardiologists have their balloon catheters. For family physicians, the fundamental therapeutic technology is our relationship with our patients. Further compromise of this relationship will have a profoundly demoralizing effect. We will be like surgeons without scalpels.

Every year my patients send me cards, bake me cakes, and bring me homegrown tomatoes. This year I am going to ask them to write letters instead. If every family physician asked just five patients to write one letter each, every member of the House and Senate would receive approximately 1000 handwritten letters from "voters back home." Politicians respond to public opinion; therefore, this simple approach could have tremendous impact.

I am sure that it will be easy for you to identify five patients like Shirley in your practice. At their next visit to your office, tell them that you need their help. Sometime in 1993, you will ask them to write: "Dear Senator: I am writing on behalf of my family physician . . ."

References

1. Dietrich AJ, Nelson EC, Kirk JW, Zubkoff M, O'Connor GT. Do primary physicians actually manage their patients' fee-for-service care? JAMA 1988; 259:3145–9.
2. Franks P, Clancy CM, Nutting PA. Gatekeeping revisited—protecting patients from overtreatment. N Engl J Med 1992; 327:424–7.
3. Rosenblatt RA. Specialists or generalists: on whom should we base the American health care system? [editorial]. JAMA 1992; 267: 1665–6.
4. Mold JW, Stein HF. The cascade effect in the clinical care of patients. N Engl J Med 1986; 314:512–4.
5. Brody H. Assisted death—a compassionate response to a medical failure. N Engl J Med 1992; 327:1384–8.