Materia Medica

Access to Care: Too Much or Not Enough?

Jeffrey G. Wong, MD, FACP

Division of General Internal Medicine and Geriatrics, Medical University of South Carolina, Charleston, SC, USA.

I thought that the first meeting would be the hardest but I was wrong; all of our meetings were difficult in their own way. My perspective was already clouded by the fact that he was referred to see me because Bill, a great doctor in his own right, wasn't able to provide them what they needed: rather, what she needed—he was fine.

In actuality, he was really, really sick—but not tragically so. At 85, he'd had a full life but over the past two to three years his body had begun to fail him. A more detailed history revealed that he'd had an MI almost 20 years ago, shortly thereafter developed atrial fibrillation and had a massive stroke several years after that—one that left him dysarthric and hemiparetic, though over time his deficits gradually and nearly completely resolved. In fact, these major past events had become relative afterthoughts, not unlike the hypertension and hyperlipidemia that caused them. He continued to be productive in his business and successful in his investments and when he partially retired and made our community one of his *three* United States residences, the people working in the development office certainly took notice.

Thirty months ago, he noticed a sore on the back of his tongue. The ENT specialist also noticed lymphadenopathy on the contralateral side from the tongue lesion; a biopsy of the tongue revealed squamous cell carcinoma. A biopsy of the lymph node revealed non-Hodgkin's lymphoma. So with two primary malignancies, three specialists (ENT, oncology and radiation oncology), and the might of the medical center behind him, he embarked on the double “full-court press”. No surgery was performed but radiation and chemotherapy “wrecked his body” as it simultaneously destroyed the dual tumors. In the throes of treatment, he was incredibly sick. A private duty nurses' aide, one who had performed similar duties for wealthy, infirm patients in Manhattan and Long Island, was hired and summoned south to live with him and his devoted wife. This incredibly taxing 24-month vigil was deemed a success—both of the tumors were rendered undetectable by any radiographic means. He was cured!

Except that the treatment had taken its toll. In the course of therapy, he had developed iatrogenic adrenal insufficiency from corticosteroids and autonomic dysfunction attributed to chemotherapy, requiring mineralocorticoids to support his blood pressure. With this turn of events, he acquired another specialist (an endocrinologist). In fact, what he lacked in blood pressure, he compensated for in specialists. His blood counts refused to return to normal (a hematologist). Atrial fibrillation and CHF impacted his condition (a cardiologist). He had “spells” during which he would blankly stare into space; on occasion his face would droop and his speech would become unintelligible. Whether these were TIAs or seizures was not

determined but, as one might predict, he also gained a neurologist who treated him for both conditions.

Not surprisingly, with his six specialists in tow, his care was fragmented, disjointed and disorganized. At one specialty visit, the physician would add medication; at another visit later in the week, a different specialist would discontinue it. More often than not, one manipulation made something else worse, so despite being cancer-free, he was frequently admitted to the hospital for short stays to sort things out.

That's when Bill got involved, the quintessential primary care general internist and geriatrician, perhaps the strongest advocate for the new health care plan and an expert on the patient-centered medical home. He saw them in his clinic and attempted to coordinate care, fielding phone calls and answering questions. He tried to ensure that all of the specialists were on, if not the same page, at least the same chapter in the story. And Bill did this all of this with his characteristic warmth, grace and good nature.

But he hadn't returned to his previous state of health, so she remained unhappy. The combination of his present ailments, his preexisting conditions, and his age rendered him frail, vulnerable, and ultimately dependent upon her care, and the care of his nurses' aide. Despite everyone's best efforts, despite requests for multiple blood tests and studies, he would still get *very* sick, *very* quickly and *very* unpredictably. So she removed him from Bill's care and placed him in mine.

I'd like to report that a fresh start with a new primary care physician made things better. In fact, he did show some improvement initially (perhaps a large amount of expectation bias and placebo effect) though I doubt it had anything directly to do with what I did or did not do. We had frequent visits—both in the clinic and in the hospital when he was admitted. During these hours spent together and without his wife present, he recognized the difficulty she had adapting to and accepting his present state of deteriorating health, seemingly understanding of the limits of medical science.

All told, we were together for about four months—a period of time involving five office visits, three hospitalizations, and numerous phone calls (some to my personal cell phone). While it appeared that he wasn't losing ground, he certainly wasn't gaining. In most busy practices, and certainly in ours, not all phone messages are answered instantaneously, and while our office nurses and staff are some of the best around, she wasn't happy with her access to our care. So they moved on again—to a local so-called “concierge” practice.

I still see his name frequently on the hospital admissions roster and I wonder how he's doing—how *she's* doing—with the new arrangement. I also wonder, if a “concierge” practice really is the answer, what that says about the essence of primary care. Primary care practices tread a fine line with wealthy “VIPs” and their families who are often accustomed to getting what they want whenever they want it; price is rarely an issue. And in academic medical centers, with budgets tightening and a growing emphasis on nurturing sources of philanthropy, there

are additional pressures on the practice from the development office to keep certain families happy. We all tried extremely hard to satisfy them, and while I'm somewhat ashamed to admit it, I am certain that he received more attention than he might have because of his "VIP" status. Yet it seems clear that the added attention did little to improve his overall health, and as he is still frequently admitted to the hospital, the "concierge" practice may not be succeeding either.

I know I tried to communicate clearly with him about the limits of what could be expected; I believe he understood. I also believe that she didn't want to hear it; when one is accustomed to always hearing "yes", it is difficult to be told "no". But as the critic Mary Colum once famously said to Ernest Hemmingway,

"The only difference between the rich and other people is that the rich have more money," and, unfortunately, for my former patient, this truth will inevitably prevail.

Corresponding Author: Jeffrey G. Wong, MD, FACP; Division of General Internal Medicine and Geriatrics, Medical University of South Carolina, 135 Cannon Street, Suite 403 K, Charleston, SC 29425, USA (e-mail: wong@musc.edu).

J Gen Intern Med 27(6):754-5

DOI: 10.1007/s11606-011-1895-2

© Society of General Internal Medicine 2011