#37 – "Payer" Versus "Patient" Centered Medical Care

When I read horror stories of government sanctioned, "bounty hunter" RAC auditors descending on physician practices I flash back to my youth. My first image is that of opening a new pair of underwear and a small slip of paper, "Inspected by #37", would fall out. I always wondered how management followed up to find out if #37 was properly inspecting the garments. I figured that a few random boxers, like a few random patient charts, were pulled "off the line" by quality control agents.

My second image involved endless conversations with my father, a full service rural general practitioner, as to why different patients were treated differently for what appeared to me to be the same situation. The answer always involved something unique about the patient such as, does not tolerate the preferred medication well, cannot afford my customary fee, or refuses the recommended treatment for personal reasons or beliefs. That was my first exposure to the "art" - as contrasted with the "science" - of medicine.

Fast forwarding a few decades, I found myself practicing what I believed was "culturally sensitive" government medicine in a Native American community. I was pleased with our "team's" success in increasing patient participation in several preventive activities, e.g. pap smears, and the perceived "trust" the population had bestowed. However, there were episodes where the patients trusted themselves over us.

One involved a fellow who dropped an object on his big toe. After relieving the hematoma under his nail, I tapped his toes together, suggested he wear a large pair of shoes for a few weeks and sent him on his way. He asked why I was not going to x-ray the toe to see if it was broken. I said that it would not make a difference in how I treated him and he did not need the extra radiation. He drove 30 miles to a local town, paid for an x-ray and returned to show me the x-ray of his broken toe.

The treatment did not change and the fellow spent money that probably could have been better used to care for his family. I felt self righteous but, reflecting years later, wondered how much "harm" would have been done accommodating him. Most Americans, directly or indirectly through insurance or taxes, pay for their health care. In the absence of serious harm, should third parties always deny them peace of mind regarding something that matters to them? What about slightly more frequent cancer screening tests for a "worried well" patient who has recently lost a close friend or relative to cancer?

When I was Chief Medical Officer of the Indian Health Service I found myself in heated debates with administrative officials as to why we could not deny private physicians payment for emergency, "rule out", cardiac workups for middle age, Native Americans presenting with "chest pain" - subsequently attributed to non-cardiac etiology. I stressed that unless a physician really "knew" a patient, especially in today's litigious environment, it would be irresponsible not to do such a workup.

I was always amused by, but skeptical of, the "back pain" example the chief architect of the ACA, former Senator Tom Daschle, included in his book, "Critical: What We Can Do About the Health Care Crisis". Allegedly, Daschle and other lawyers had located a man who, absent health insurance, was sentenced to a life of chronic pain, unemployment and addiction.

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First, I doubt that if the fellow truly suffered from neurological deficits the surgery would not have been performed. Secondly, the "science" speaks to the contrary. On July 29, 2013 both *USA Today* and *Los Angeles Times* note a JAMA - Internal Medicine study of how physicians are ignoring established standard guidelines for the treatment of back pain (NAISD and physical therapy), dangerously overdosing patients with addictive narcotics and imaging radiation that could lead to increased cancers. Under ACA government guidelines, it is doubtful Daschle's patient would have even received narcotics and imaging studies, let alone, the alleged surgery that would have cured the pain and made him a contributing, productive member of society.

I am a strong supporter of comparative effectiveness research, evidenced based medicine, standardized guidelines and other QI tools to enhance the "science" of medicine. However, if the "art" is lost by denying physician the requisite professional judgment and flexibility, patients will suffer. One of the greatest physicians, Sir William Osler, said it best, "The good physician knows the disease the patient has; the great physician knows the patient who has the disease". That is not #37.

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