HEALING ARTS

Materia Medica

On the Value of the Primary Care Physician

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She called me Brent and I called her Martha. Yes, that's her real name, not a pseudonym, and I asked her family if I could use it in this piece. It's important, because it was *her name*. Martha and I moved beyond the patient-physician relationship to friendship. It was a winter-summer connection, as she was 97 and I was 49. I cared for her a majority of my career at that point, but those 16 years were a little less than 16% of her life. And at 97, the time for her was flying by.

Martha moved to my city after her husband died. She came to me as a new patient in her 80s with the different diseases she acquired during the journey of her long life. But, she also had a touch of somatic symptoms disorder. She was a perennial chump, and I mean that with all due respect, for direct mail marketers of herbal health products. From my standpoint, I was her protector, as she brought with her every month pamphlets and fliers to ask if I thought she should try the latest and greatest supplements.

Yes, monthly. I always worried that Medicare would come after me for bilking them over this one patient. But Martha needed to see a doctor monthly. I remember my mentor, Dan Duffy, the former Vice-President of the American Board of Internal Medicine, teaching me during residency about the care for patients with multiple somatic complaints like Martha. Seeing them monthly is "therapeutic" for them, and by doing so, their anxiety about living life decreases.^{1, 2} This was Martha. Even as my administrative load in our health system increased, we worked her monthly visits into my calendar. She commented to me multiple times, "I tell my friends at the Assisted Living Center my doctor says I have to see him monthly." It was a badge of respect she wore proudly. Had she not showed, I would have missed her greatly.

She always credited me with her health, which was overstated. I could never fix her incontinence, though we tried every medicine and consulted gyn-urologists often. Overall she was naturally healthy. My role was to keep other providers from doing things to her—adding medicines to her list, or putting her through procedures. I went to see her in the hospital when she presented with congestive heart failure in her mid-80s. She was cathed against my advice, and her coronaries were normal. She drank wine daily, and cardiologists speculated that her drinking could have caused her cardiomyopathy. But I demurred, as she never was intoxicated nor smelled of alcohol in any of our frequent visits. Still, I suspected that CHF would be the spiral toward the end. But it wasn't. Six months later her ejection fraction rebounded to normal.

As she slowly lost weight from routine aging, her diabetes began to disappear. She had chronic osteomyelitis from a joint replacement gone bad, but her daily double oral antibiotic therapy kept it at bay. Nonetheless, joint pains increased enough that I watched her move from using a cane, to a walker, to a motorized scooter.

She must have read 150 or more best-sellers during the time I knew her—every visit she held in her hands the latest Tom Clancy or Lee Child book as I entered the room. "Well, hello there, Brent," I can hear her now, smiling and looking at me over her reading glasses. This served as my indicator she was not developing dementia—she could describe each plot in detail. She was sharp to the end.

Eventually, I moved into healthcare administration, but continued to see patients, including Martha, one session per week. I learned during that time about the "value" of physicians. Most of the specialists in large health systems earn anywhere from 1.5 to 4 times the amount of a primary care physician. Specialists, particularly proceduralists and those who use high-end diagnostic and therapeutic techniques, bring the revenue to hospitals and ambulatory surgery centers. Competitive health systems develop networks of primary care offices to "feed" the specialists, the procedure centers, and the hospitals. There is a tendency to "sell" those high-end specialties on billboards, magazines, and the evening news: the latest technologies, the highest sub-sub-specialty physicians, the smallest incisions, the most precision radiation, the "least invasive" therapies.

In all this advertising and promotion, the primary care physician is a faceless, nameless cog, cranking through visits with highly complex patients, and very low-tech instruments. I still use a stethoscope that has not advanced significantly since it was introduced by Laennec in 1816.³ My most common procedure, the PAP smear turns 90 this year, generates a net negative income, and, while the speculum is now clear plastic, women still endure the same discomfort.⁴

Many patients *want* a primary care physician. But how many health systems have you seen advertise "Come see our primary care physicians, the kindest, gentlest in the city"? Health policy gurus lament the shortage of primary care physicians and the primary care "deserts" in rural states. But our students and residents get the message. Primary care is relatively underfunded, unappreciated, and unattractive.

So, I ask the questions: What is the value of a primary care physician? How is that value measured? By whom is it measured?

I'm no longer in a fast-paced, competitive health system administration, and instead spend the majority of my week seeing primary care patients. To me, the value of a primary care physician is in our relationships with people (I do mean "people," not "patients.") People whose lives intersect with primary care offices mostly in their minor physical annoyances, and sometimes in their major, life-altering maladies. People who are looking for someone they can trust during those times to know the difference between the two. People with stories and names, like Martha.

Toward the end, she told me, "I'm tired, Brent. I don't sleep well. I hurt all the time. I miss my husband terribly. I don't want to be here anymore." The last months of her life, I went to visit her, rather than expecting her to come to my clinic. She became too frail and rarely left her room at the assisted living center.

My last visit with her, I sensed that she was not long for the world. So, I found the head nurse, ensured Martha's living will was readily available, and coached her, "Please let everyone know, we want Martha's death to be comfortable when it comes. No code blue, don't call the ambulance." The family, the nurses, Martha—we were all in agreement.

In the words of Robert Burns, "the best laid schemes o' Mice an' Men Gang aft agley." Martha had "a head bonk," and developed delirium. When she became unarousable, a well-meaning tech called an ambulance. They intubated her, and drove her the four city blocks to the hospital, where a CT scan confirmed the severe subdural hematoma. She was sent to the neuro-intensive care unit. When her family arrived, she was extubated and allowed to pass. I attended her funeral where her family graciously thanked me for the care I provided her. I felt humbled and grateful for my relationship with Martha.

Even now, reflecting on this patient, I ask myself, "What's the value of a primary care physician?" There is a reason we are called *primary*. Ours is a patient's foundational relationship with the health care system. It's where they start. Patients like Martha value the counsel they receive when they are ill, and the assurance when they are not. Could I monetize the value

of health care savings and estimate the decrease in potential morbidity from steering patients like Martha toward safer choices? Certainly, and others have done so.

But, there is also value in what being a primary care physician brings to *me*—the riches of relationship, the implicit bond between two people, brought together over the most personal and secret discussions in a lonely examination room. The cornucopia of wisdom all my Marthas bring to me through their sum-total life experiences is inestimable. I learn what enhances life: a good glass of red, a thrilling page-turner, maintaining continence at lunch with friends, preserving mobility to take a field trip to the Dollar General.

I was invited to, and attended, Martha's 90th birthday party with her family and friends, and was introduced to her children, grand-children and great-grandchildren. That's the way I like to remember her, arms around those she loved, smiling and present with them.

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Compliance with Ethical Standards:

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