

## REFLECTIONS IN FAMILY MEDICINE

## Bandaging Society's Wounds: A Primary Care Perspective

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**Our patients often carry heavy burdens into the examination room. With our standard questioning, we medically divide and define them into recognizable parts, but as pieces of a whole they resist healing. Can we regain a vision of health beyond the isolated individual to one who might belong to a larger community of concern? (J Am Board Fam Med 2010;23:121–123.)**

I recently received a voicemail message that both surprised and disturbed me. A patient called to say that she was discharging me as her doctor. It had never really happened before in such a formal way. Although patients come and go, and their leaving is probably at times an indirect expression of rejection, this message was anything but subtle. Although I was partly relieved, given her dissatisfaction with my ability to help her, I felt the shock of an acutely ruptured relationship. I had “lost” a patient. Did I miss the diagnosis? Fail to treat what was treatable? Forget to listen and to communicate crucial understandings?

The details of the story are not unusual given our country's system of fragmented health care. My patient was 64 years old, morbidly obese, and in chronic pain at least in part caused by advanced arthritis in her hip. Although she would need to lose some weight before a surgeon would consider joint replacement, surgery was not an option because she had no insurance, at least for a year when she would become eligible for Medicare. She sat in a crack in the system. Because 70% of my patients are uninsured, I would think I would be used to it—but I never am.

My team and I spent several months experimenting with various combinations of pain medicines that could provide relief while remaining

within our patient's budget. Because of a range of intolerable side effects we turned to a patented product. Although the patient could not afford it, an indigent care program offered the medicine at no cost if we filled out the forms and waited 4 to 6 weeks for delivery. The week the medicines were to arrive was the week my patient discharged me. From her perspective she had no other choice: the pain remained and therefore I had failed to fulfill my obligations as her doctor.

It would be easy to lay the blame on a broken health care system that often fissures and becomes a gaping chasm into which people fall. This patient's insurance status created barriers. But is it fair to assume all would be well if she had that little card that opens the doors to our vast and powerful medical establishment?

Our technology works so well when a broken part needs fixing. If not the next new medicine, then surely a new hip would solve her problems. But this patient's story was more complicated (aren't they all?). She had a disabled husband, a lonely life, a relationship with food that was a substitute for a fulfillment of deeper needs. Weight loss was a worthy goal, so I assessed her stage of change and dutifully gave her the handouts. But underneath the superficial fulfillment of my obligations to recommend behavioral modification I knew she could not see the future with enough hope to begin to change. In context it is clear that hers was not just objective pain. She suffered at a level that resists measurement and remains mysteriously personal. Yet in so many cases we arrive at the default—unwritten but understood as a part of the contract—that the doctor will solve the prob-

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lem and relieve the pain with the power of the pills at their disposal.

Deep down I feel something has gone wrong. When I committed to primary care 25 years ago, I looked forward to the privilege of working with people through their struggles and sicknesses. I never wanted to have expectations placed on me that I could simply erase problems. Yet now more than ever I feel the weight of that responsibility. From where does that feeling come? Is it because we live in a society that has lost the art of suffering because we think our advances make suffering unnecessary? Or have we, the medical profession, made promises we really cannot keep when we say that we can control—ie, vanquish—all pain? What medicine promises and what society expects seem to synergistically feed this ever-expanding myth that eventually loses contact with the daily realities of individual lives.

A few years ago my father was nearing the end of his life. He had had repeated small heart attacks and his heart was failing him, slowly but surely. Although his medical care alleviated much of his discomfort, he struggled for quite some time before he died. With a physician as a son, having excellent services, good health insurance, and many strong advocates, my family and I assumed the medical project would deliver on its promises and he would not suffer at the end. When this did not happen, I had to relearn the fact that medicine has limits, that not all of his distress was avoidable, and that his suffering did not diminish him but only enlarged his stature to all who knew him to the end.

What have we lost in medicalizing pain and suffering to the degree that renders it so completely meaningless, void of value, simply a symptom to treat and cure? In his 1976 critique of medicine,<sup>1</sup> Ivan Illich said that we are capable of reducing the health of a society when we make pain a technical matter and assure its relief. If health is more than just the absence of disease but also includes the ability to “feel alive in pleasure and in pain, ... to cherish but also to risk survival,” then our current view of pain and suffering is highly inadequate. To struggle, to risk, to endure, to overcome is—or ought to be—an important and necessary part of the human experience.

But we need a framework in which to translate these realities since they come to us as if in a foreign, unknown language. Illich emphasized the importance of culture because it alone can “make

pain tolerable by interpreting its necessity; only pain perceived as curable is intolerable.”<sup>2</sup> My patient lacked such a culture through which she could redefine her struggles with hope. At one point I suggested that our medicines could help but some pain might remain. As a person alone and suffering, I don’t blame her for finding this unacceptable. Although I tried one last time to reach out across the separation, I was not surprised when my letter of regret for the loss of our relationship brought no response.

It is a normal and natural human reaction to avoid situations in which demands exceed possibilities and “feeling overwhelmed” becomes a constant companion. Is this one of the reasons so many doctors are retiring at my age and so few new graduates are choosing primary care? It is exceedingly difficult to remain in relationships with patients who are struggling with life while feeling powerless to “deliver the goods,” so to speak, when those “goods” are the deliverance of the patient from life’s afflictions.

I believe that we are fighting a losing battle in primary care if we continue to accept the status quo. We have historically not been that part of medicine that treats people as a sum of many parts, each one having a technical solution when it breaks. The whole that is the person always exceeds this sum, and the capacities to persevere and heal can surprise and amaze when one is understood as a fully connected human being capable of goodness and even greatness. What so often is missing are the threads that hold it all together.

As I reflect on the loss of my patient, Wendell Berry has offered a perspective on health that is helpful. He writes that “the community is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms.”<sup>3</sup> Isolation is an unhealthy state of affairs. This is not such an amazing revelation, yet many of us practice as if it is big news. We meet our patients one-on-one but face realities that only make sense in the larger community in which we live. If this patient had been in a community with others who were overweight, others in chronic pain, others caring for a disabled loved one, or others who simply cared about her, maybe the pills would have been more helpful. Can we help and hope for expanded relationships that nurture and support those who come to us?

We who are primary care practitioners at the front lines can advocate for a larger view of illness that acknowledges the burden but explores the opportunities for healing in larger contexts that are not based on only a pill or procedure. Of all members of our society, we should see the limitations of a restricted and reductionist view of human life and call for more. This true and traditional primary care approach to health and illness can benefit all of us—patient, practitioner and the community at large—and help to sustain our specialty and under-

line its importance as reform brings health care in the United States into a new era.

## References

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