Two Sides of the Same Coin

Barry Blackwell, MB, BCh, MD, FRC Psych

Separated by the Atlantic Ocean but united by a common heritage, Britain and America share a pressing problem on which they disagree fundamentally: health care—a rather abstract and philosophical debate that recently became personal.

Now an American citizen, beyond age 77, I visited my internist for an annual medical exam. Newly retired, we addressed several deferred decisions. Twenty youthful years of playing rugby and pushing in the serum had wreaked havoc with my joints. I have had a hip replaced (followed by a pulmonary embolus), both knees are arthritic, and I suffer from spinal stenosis, severe on x-ray but mercifully asymptomatic. In addition, I have an ataxia of undetermined origin so my gait resembles an inebriated penguin walking on stilts. My eligibility for safe surgery is compromised by atrial fibrillation and anticoagulants. Despite this depressing litany, both my internist and orthopedist contemplated bilateral knee surgery, separated and followed by several months of prolonged rehabilitation at an estimated cost probably in excess of $100,000. The alternative, a gradual progression from cane to walker to wheelchair eased by palliative analgesics might cost $5000.

Next, I had previously undergone 2 colonoscopies, 5 years apart. Despite best practice guidelines that suggest colonoscopy after age 75 is unproductive (even if positive you are more likely to die of something else), the gastroenterologist sent me a reminder for a repeat procedure and my internist felt I should go ahead, "just to be safe." I scheduled the colonoscopy but had second thoughts and cancelled the procedure, presumably saving Medicare a significant sum while short-changing the hospital and gastroenterologist.

Finally, a new concern raised its head. My platelet count was marginally low for no apparent reason (140,000). One possible cause was my Churchillian propensity for heavy social drinking, to which I willingly confessed. Might an enlarged and dysfunctional liver be suppressing splenic function? Perhaps I needed a nuclear medicine scan of both organs at the same time as a repeat platelet count. The latter came back normal, but the scan was already scheduled. It was reported as showing a liver and spleen both "twice the normal size." This led to scheduling a chest x-ray and CT scan of the abdomen and pelvis for a more definitive view of the liver. Alarmed, I embraced total sobriety during the 3-week hiatus before the results came back; they were normal. My internist concluded that the false positive scan likely was not due to my rigorous sobriety but to "an inexperienced radiologist." I estimate the cost of these procedures must have exceeded $10,000. (I was told that the brand new CT scanner, of which the hospital has three, cost over $1 million).

At exactly the same time these events occurred, my 84-year-old brother in England viewed the reverse side of the coin. A former Royal Marine and retired Superintendent of Police, he is legally blind, physically handicapped, totally housebound, and completely dependent on his 74-year-old wife for support. In the preceding 3 weeks, his wife suddenly had developed severe back pain and became bedridden. The pain had not responded to several pain killers and muscle relaxants and failed to benefit from 2 sessions of physiotherapy and a visit to a chiropractor. The local general practitioner had conducted a brief home visit and examination but made no definitive diagnosis and declined to request an x-ray. Concerned, my brother called the National Health Service regional hotline resulting in a phone diagnosis of "probable sciatica" and a prescription for Valium. When this failed to improve matters, he called the local hospital to suggest admission and request an x-ray but was turned away and told there were no x-rays available on weekends.

My brother's true predicament was that they had been shunted into the "care" continuum. So the issue became disposition, either in-home care or a long-term facility rather than diagnosis or treatment, now

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Barry Blackwell, MB, BCh, MD, FRC Psych, is emeritus professor of psychiatry and former chair of psychiatry, Milwaukee Clinical Campus, University of Wisconsin School of Medicine. He can be reached at Saint John's on the Lake, 1800 N Prospect Ave, Apt 15 C, Milwaukee, WI 53202; blackwellbarry@hotmail.com.

deemed irrelevant. This was the responsibility of social workers, not doctors, and of a new "for-profit" industry providing in-home assistance for $15 to $30 an hour. The only thing delaying this option was the fortunate fact that my brother's middle-aged son was laid off work and able to assume their care temporarily.

My first response was stereotypically American; it was outrageous that a more aggressive attempt had not been made to reach a definitive diagnosis. No x-ray, no CT scan, no referral to an orthopedist, just symptomatic treatment and disposition—all ineffective. But then I began to recall my early days as a family doctor in Britain and weigh the odds. Statistically, by far the most common cause of sudden onset back pain in a healthy 74-year-old woman would be musculoskeletal. Even if it was something more sinister, perhaps a metastatic lesion, the treatment was likely to be palliative. Hadn't we been taught that when scanning the diagnostic parking lot a Ford was far more common than a Rolls Royce? The reality of my brother's total disability and dependence on his wife, as well as their ages, made a move into a long-term care facility seem inevitable. Why not sooner than later? Even without a job, my brother's son had an independent life to lead. The psychiatrist in me wondered if part of the predicament and lack of recovery might be due to carrying a burden of care his wife no longer felt able or willing to bear. I sensed my brother already knew this and was beginning to accept its implications.

Back in America my anger melted, transformed into more support and less advice. But the policy implications lingered; as with so much these days the issues seem inflated by political rhetoric focused on exaggerating differences rather than attempting compromise.

In Britain, it might help to pay empathic and more nuanced attention to accurate diagnosis, easing acceptance of disposition before crossing the Rubicon from cure to care. In America, we might learn that not everybody can have everything, especially immortality. Clinical guidelines, firmly applied, might rationalize the fair distribution of resources and feel less like rationing, which Brits culturally are inclined to accept but Yanks fiercely resist.

Overall Britain appears to be holding the fiscal line while, in America, costs are escalating out of control in an aging population even though Medicare pays physicians less than market rates and politicians are debating radical change.

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