# REFLECTIONS:
# One Patient's Short, Short Story:
# Is There Time to Craft a Happy Ending?

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*Continuity is one of the key elements that constitute the construct of primary care (Franks, Clancy, & Nutting, 1997; Rivo, Saultz, Wartman, & DeWitt, 1994), and is foundational to the concept of a "personal doctor" (Taylor, 1997). But in an era of managed care and large group practice, it is an increasingly rare commodity to obtain (Taylor, 1997). Family medicine is particularly concerned about continuity, and training programs worry that their preparation of residents may be inadequate in this respect (Tannenbaum, 1998; Irby, 1995; Steiner, & Stoken, 1995; Tannenbaum, 1998). Residents change clinic schedules, take vacations, get sick, travel to "away" rotations, graduate. Patients cancel appointments, are late, are too sick to keep their appointment with their doctor. A Canadian study found only between one-fifth and one-quarter of patients experiencing continuity visits (Bell & Szafran, 1995). Survey data conclude that continuity in patient care is associated not only with patient satisfaction (Flocke, 1997), but also with physician satisfaction as well (Randall, Bergus, Schlechte, et al., 1997).*

*Continuity with "difficult" multi-problem patients is especially important. Yet these are precisely the kinds of patients, with depression, histories of domestic violence, family and relationship problems, and perceived by their physicians to be "difficult," who are most likely to not receive continuity (Sweeney & Gray, 1995). For example, lack of continuity in the physician-patient relationship is identified as a barrier to the diagnosis of depression in primary care settings (Docherty, 1997).*

*Residents and faculty help each other by filling in the gaps. Usually the system works reasonably well. But sometimes health providers are dropped into a reality much different than expected. In particular, patient and provider(s) struggle to agree on an acceptable story (Brody, 1994; Marta, 1997). In the case presented below, the patient longed for a "happy ending" to emerge from the visit, a "restitution story" (Frank, 1995) that would restore her life to pre-illness wholeness. The providers, on the other hand, were forced to realize that this patient was at the beginning of a long journey (Hawkins, 1993), that could not be completed in the cross-section of time available to everyone involved.*

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The clinic medical director knocks on the office door. He is apologetic for the same reason he is usually apologetic: he has a favor to ask. "This is about customer satisfaction," he begins. A patient is here, appointment slip in hand. She has come for a counseling session. The patient is here, but her resident and the resident's supervising behavioral scientist are not. A typical scheduling foul-up. Could I, also a behavioral scientist, see the patient with the supervising third year? Why not? We agree.

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This is already a familiar, recognizable story in a busy family practice residency training clinic. A patient is present, in pain, asking for help, but her continuity physician is nowhere to be found. The system has blundered, has created disjunction, but like a tragic hero (Poirier, Rosenblum, Ayres et al., 1992), lumbers on, determined to pull a happy ending out of an unlikely beginning. There is also the incipient outline of the health providers' story: My third year and I will provide a new sympathetic ear for this system-frustrated patient. Although we don't know this patient, will likely not ever see her again, we are eager to salvage the story of her day's visit; we are eager to give her story a happy ending, so we can return to our charts, our other patients, our other responsibilities. We do not yet know the patient's story.

Luckily, she is willing to tell it once again to yet another set of uninformed, but helpful, strangers. It takes time, because it is not a simple story, and we automatically begin to put her story into our words (Hunter, 1991), because her words take up a lot of room. Her last name is faithfully recorded on her chart, but somehow she quickly becomes Sandra ( the resident and I exchange glances, telegraphing "we probably shouldn't be calling her Sandra," but pretty soon we have other things to worry about). Sandra gives her age as 41, although her chart tells us she is 39. She is thin and pale, with deep-set brown eyes and badly dyed, curled hair. She has been to our clinic on three prior occasions, once an urgent-care visit for intermittent epigastric pain, once for follow-up, and once for evaluation of "anxious, angry mood, low self-confidence, and poor self-esteem." She is currently single, although she was in a six-year marriage that was emotionally and physically abusive. She managed to leave (good for her, I think: shows she's got something to work with!). She has no children ("thank God," she adds, and I think, that's a lucky break!), and has no contact with her family of origin (her mother is dead, her father is alcoholic, and she has not seen her older sister in two years (too bad! No family support, I check off). She has a history of childhood sexual abuse (we do not stop to find out for how long) by someone variously described as an uncle and a "friend" of the family (this is going to be complicated, no quick fix here). She has a history of destructive relationships. She has worked "with the public," in receptionist and sales positions, but is currently unemployed (another strike!), and has only the most basic state-provided health insurance. She asks in passing whether we know the difference between disability and general relief (oh-oh! I cringe involuntarily at the word "disability", although both the resident and I have been down this road countless times before). She reports that, her whole life, she has allowed her identity to be determined by others, her father, her boyfriends. She wants to figure out who she is, "if she is anybody at all." She has difficulty concentrating and remembering things, and thinks she is stupid.

In general, Sandra feels worthless and despondent about her life. She experiences little pleasure, although she reports she still enjoys going to the movies and eating Mexican food. She has been depressed "as long as I can remember," and often feels "dead" inside. We assess her suicidality carefully, but although she frequently longs to "pull a switch" to end her life, she is repulsed by the thought of actually doing away with herself, and has never made any attempts. When we ask her about overdosing on pills, she replies, "I see pills as a positive. I know they're going to help me. I'd never take too many." Sandra is also chronically anxious, and reports episodes of shortness of breath and a sense of the world closing in on her several times a day. She often goes several nights without

sleeping, and reports frequent "bad dreams." She's had a hard life, the resident sadly sums up later.

Three years ago, she was under the care of a psychiatrist who tried her on a variety of antidepressants without much success (she remembers Paxil, Welbutrin, Prozac), until he stumbled on a magic triumvirate of Xanax, Valium, and Trazedone, which Sandra states "made her feel much better and helped her sleep." Unfortunately, due to "financial problems," the doctor closed his office and disappeared. In the interim Sandra has been "bumming" Trazedone and Xanax from various friends, primarily her roommate. In particular, "Xanax is the only thing that makes me feel normal."

Because we rushed through Sandra's illegibly scrawled chart, we do not at first realize that Sandra's continuity physician at our clinic has already referred her to county mental health. Now we learn she is being followed by a counselor at this facility, and was also evaluated by a psychiatrist there. The resident and I exchange glances again: Precisely what is our role here? Are we providing additional support? Monitoring her care? The psychiatrist prescribed Buspar, which Sandra has been taking for a week. She complains it does nothing to alter her anxiety symptoms, and makes her feel "weird" and "spacey." She would like to be prescribed "the drugs that worked," and upon being informed that her county funding would not cover any of the medications she thinks she needs, responds somewhat airily, "I can borrow the money to pay for them." (They must be pretty important to her, I think). It took some time, but Sandra has finally told us her happy ending.

Now she looks at us hopefully, but we are confused and dismayed. Initially we assumed we were covering for Sandra's continuity physician, but we realize Sandra would also like us to be "covering" for the county psychiatrist who is managing her psychiatric medication. Willing strangers, we wanted to be helpful, to give Sandra a satisfactory conclusion to her visit, but we are beginning to feel there are too many chefs in this kitchen. Also, we are afraid we recognize Sandra's story already. In fact, we have stock phrases that encapsulate it succinctly: "drug-seeking," "disability-seeking," "doctor-shopping." We are already thinking about personality disorders. Given her history of abuse, she could well be "borderline". Another stock phrase conveniently pulled out of our repertoire. Not only do we recognize this story, we think we know how it will end, and it is not happily.

Time is passing. We hear the proverbial knocks on the door. It is time to move on to other patients, other problems, our quotient of caring for this patient has been expended. The joyful finale so eagerly sought by us all is proving increasingly elusive. We explain the dilemma: "It's not a good idea to have different doctors trying different treatments for the same problem." Sandra is unmoved. That's our problem. Her problem is that she can't sleep and wants to pull a switch on her so-called life. We suggest alternatives: "Give the Buspar a chance. It's still too early to know if it will help." "Follow-up with the psychiatrist. You only have to wait one more month." (A whole month! I can't help thinking). But Sandra mistrusts the mental health system. "That shrink doesn't care about me. They won't help me over there. Besides, I can't hold out a month." Sandra knows her part well. Friendly at first, she is now angry and hostile. She pushes once more for her happy ending. "What I'd really like is at least the Trazedone. That helps me sleep."

Outside, we wonder, what can be done? It is hard to know. We realize we are not her doctors - we are standing in line behind the continuity physician, the psychiatrist. We have rushed through an evaluation on the spur of the moment that has probably been done more completely by others. We

are left with unanswered questions. Is she depressed? Is she borderline? Is she depressed and borderline? Is she having panic attacks? Is her course of treatment appropriate? Did the psychiatrist hear her pain as we hear it now? Is she willing to receive the hard, painstaking kind of help we hope the mental health counselor can offer her? Did her continuity family doc evaluate the neurofibromatosis she mentioned as we walked out the door? Time is running out.

Hastily, we try to craft another ending (Bracero, 1996). Not a happy ending, but at least a good-enough ending. It is not well-worded; it is like a first draft. It has some potential but needs a lot of work, which we do not have the time to give it. We try to negotiate today's conclusion with Sandra. "Stick with your psychiatrist," we urge her, "at least until your next appointment. See your mental health counselor three days from now and express your frustration and mistrust. Ask for more help. Explain you are suffering. And stop bumming drugs from your friends. We do not want to abandon you, we can listen to you and support you, but we cannot help you in the way you want. We will send a note to your counselor expressing our interest in your well-being and ask for coordinated communication about your care. Come back to clinic next week, after you have seen your counselor, and talk over what happened with your primary care doc. We want to figure out a plan that will help you, but this is all we can do today. Let's make this a process," we plead.

Sandra is no longer angry, but she is passive, withdrawn. She knows we hold all the cards. "Do I have a choice?" she says. It is not the answer we hoped for, but it is better than nothing. "At least can you refill my Tagamet," she asks sullenly, and we jump to comply, happy to do something tangible to ease her epigastric, if not her emotional, suffering. "We do not want to hurt you," we reassure Sandra. But Sandra is hurt, and whether she will have the will to negotiate her pain with a psychiatrist who is probably, like most county psychiatrists, difficult to access and overburdened, is uncertain. Whether she will return to our clinic, where her happy ending has been rewritten into something less palatable, is likewise uncertain. "I'll come back next week," she says when we ask her, but we do not know whether this is a promise or a propitiatory lie.

Yet we think we saw small signs of hope in our conversation with Sandra. She has a few loyal friends, and they tell her she is a good, caring person. She has some insight; she does not duck and weave about her problems. She has gone back to school; she might be ready to work on herself. She claims to want counseling and guidance as well as drugs. She showed significant courage in being transparent and self-revelatory with two strangers, regardless of her motives. We think there could be something to build on here. But are we only deluding ourselves, still questing for the ever-receding happy ending? Just how cynical should we be about this woman whom we have met once for less than an hour? If only we had more time to get to know her, to discover whether we could trust her, and whether she could trust us...

But we have no time left. Our chances are all used up. We worry we have relegated Sandra to some kind of alienated limbo where, left to her own devices, she will toss and turn sleeplessly, chasing bad dreams, despising the self she does not know, "borrowing" the drugs she needs to dull her self-loathing and despair.

If only there were more time, we murmur to each other, as we watch her leave, a thin, tense, pretty woman, still trying to find a happy ending to her story.

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