MEDICINE AND SOCIETY

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The Spy Who Came In with a Cold

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It's an express care clinic, next door to a smoke shop in the mall. The website advertises on-site radiology services, and that's all we want, an x-ray. In response to our request, the receptionist arches an eyebrow; she hasn't heard that one before. "You'll need to see a provider first," she says.

Looking around, I can't tell who that might be. Everyone who works here wears gray-green scrubs and a long white coat accessorized with a shoulder-draped stethoscope. "Do they ever use it?" I wonder, recalling my old Littman fondly. Not that it matters — the employee uniform here is driven by management, not medical, priorities: they think it professionalizes the workplace and democratizes the workforce. "We're a team," the clinic's website proclaims, "and we're on your side."

The opposing "side" isn't identified, but given the clinic's marketing shtick, I'm surprised its customers look so sick. An old guy with Parkinson's shuffles past us, painfully slowly, his arm shaking hard in a makeshift sling. *(He's alone? How did he get here?)* An excruciatingly thin teenage boy with bad cerebral palsy grunts at the girl pushing his wheelchair. *(Mom? She's his mother? She looks like a teenager herself.)* An unkempt woman of indeterminate age rocks restlessly in her seat, head in hands, chanting "Sancta Maria, ay-yi-yi."

Janice coughs, that frightful wracking squawk that's ruined our vacation and kept her awake for days. She's afebrile, and her lungs are clear — I've listened repeatedly, most recently an hour ago — but Janice isn't buying my diagnosis. "A cold?" she scoffed. "That's what you said when I had pneumonia, remember?" Oh, I remember: a classic case, mycoplasma probably, those ugly infiltrates discovered belatedly, belied by her benign exam. The chance that the same thing is happening again, 30 years later, seems vanishingly small, but that's why we're here. Worried well? Well, yes, but how well can you be when you're worried?

We wait our turn, but the queue moves quickly, and soon we're sitting in a small, clean examining room, and Janice's normal vital signs are recorded (no stethoscope required) by the young aide. "Better than mine," she tells Janice with a reassuring smile, but Janice has heard that line before.

"I'd like to get a chest x-ray," says Janice, but the aide seems not to hear.

She inquires about Janice's "usual" medications, not once but twice, her double-take redoubled when the answer is the same. "No meds?" she says, incredulous. "The doctor will see you soon."

She's young, too, no more than a few years out of training, her long hair pulled back in a tight, professional ponytail. "Good, good," I think, "God knows we need more women." (There were three in my med school class, all stars.) She talks fast, but she listens, too. No, no fever or chest pain or shortness of breath.

"Sputum?"

"Very little."

"Any blood?"

"Oh, no!"

"And the congestion, blowing your nose?"

"Not much, kinda watery."

"Have you had the DPT booster — you know, for whooping cough?"

"Yes, a few years ago, when we went to Africa."

"Good," I think, "she's good, all the right questions."

At first, it's only the doctor's eyes that worry me, that half-empty, wistful gaze I know so well, like she slept last night but not the night before. She looks alert but hurt, eager yet ambivalent, like she's not sure she wants to be here but here we are, so let's go. I notice her wedding band, wonder if she has any kids — day care, maybe, or a nanny. That could explain her eyes, of course, but it can't excuse the rest.

It starts with the otoscope and goes downhill from there. She handles it amateurishly, the

scope's viewing end held stiffly upright in both hands, thrust pointedly at Janice's ear. I want to show her how the pros do it, the Peds people and the ENTs, but it's not my place, not here, so I bite my tongue. (It's different where I volunteer in retirement, "coaching" new attendings on the wards of a big-city teaching hospital. There, the house staff and students suspect I'm a spy for their program director, not a coach for their teachers.) Janice doesn't flinch a bit, the otoscope in and out, fast and easy. "Ears are plugged." *(Plugged?)* She shines the light in Janice's pharynx, no tongue blade, a fleeting look. "Got some mucus back there." *(Mucus? Back where?)* She spread-eagles her hands across Janice's face and presses her thumbs hard into her cheekbones.

"That hurt?" she asks, nodding.

"Sure," Janice says, "a little."

"Mm," she says, like she already knew this. She steps to the sink and begins to wash her hands.

Whoa! Wait! We're done here? What about her chest? That's why . . . .

As if on cue, Janice coughs, the staccato burst of a semi-automatic. She struggles to catch her breath, can't speak, wags her curled finger in the air, an unspoken question mark. "Ah," the doctor says. She snatches the stethoscope off her shoulders, places its bell somewhere on the back of Janice's sweater. "Deep breath," she says. "And again," she says, listening to that same place twice, and then she's done. "Yeah, you got some noise down there."

Noise? Down there? You think it's the sweater, maybe? I've been peeved about this for years — not just the bit about the clothing and when to use the bell but how listening to the back doesn't mean you've examined the lungs — but I've pretty much given up on all that, bigger things to bitch about these days.

Janice turns to the doctor. "It's pneumonia, right? I've had it before, you know. That's why we came in, for an x-ray."

This history elicits no curiosity.[1] I wonder if she's ever seen mycoplasma, knows what makes "atypical" pneumonia atypical, why it's easy to miss. "No," she says confidently, shaking her head. "There's no need for an x-ray. The antibiotic for your sinusitis will treat your pneumonia, too."

Sinusitis? Bacterial sinusitis? And . . . and pneumonia, too? Too?

Janice shoots me a look, that glint of told-you-so: See? But there's more to it than that, a hint of deference, too: So? What do *you* say, *doctor*? Usually, Janice goes along with my undercover act, my preference not to reveal to her physicians that I'm a physician myself. It's been educational: the dermatologists who insist on Mohs surgery to remove small superficial basal cells; the ophthalmologist who needed "cardiac clearance" before doing a simple office procedure; the podiatrist who wouldn't treat plantar fasciitis without an MRI. But this time, Janice wants me to speak up, advocate on her behalf. I play the supportive husband, not the hectoring, unrequested second opinion.

"My wife's been very worried about this, doctor. She'd really prefer to have the x-ray. Find out for sure, you know?"

She shakes her head again, says something ominous about unnecessary radiation. *(Yes! Exactly!)* But then she smiles wryly and makes a servile bow. "We aim to please," she says.

A half hour later, the x-ray's done but we've heard nothing. "See?" Janice says, more worried than before. I leave the exam room, find the doctor at the central station hunched over a computer. She points to the image on the screen, says she's waiting for a reading from some radiology group across town. "Looks like the pneumonia's in both lungs," she says.

I'm relieved — I can see on the screen what she's talking about — but I don't say so. As with the otoscope and stethoscope and "sinusitis," it's not my place to teach her about breast shadows on chest films.

Still, I can't help wondering: Whose place is it, then? Clearly, she's over her head (and needs a coach) or just going through the motions (and needs more than that). Do the people who run this place know that? I'd bet her customer satisfaction scores are fine: she's brisk but affable, shares information jargon-free (that mucus, that noise), her professional persona prudently paternalistic (radiation risks) but "patient-centered," too ("We aim to please"). No, I'm sure she's flying under the radar. They'd need a pro — a spy, like me — to see what's happening here.

But who would want that job? Coaching doctors is one thing, spying is quite another: not only does it feel snarky and meretricious, it can't be trusted, either. We've known that ever since Donabedian dissected the dizzying dilemma of measuring the quality of medical care, including

the "special difficulties" of achieving "neutrality and detachment" when assessing outpatient care.[2] He saw that spies ("trained observers") are inherently unreliable, their appraisals confounded by the Hawthorne effect and observer bias. Yet, ultimately, Donabedian concluded that measuring the quality of care requires "understanding the medical care process itself" — what actually happens "at the level of the physician-patient interaction." In his view, quality researchers cannot hope to answer the question "What is wrong, and how can it be made better?" without first asking, "What goes on here?"

But if trained observers can't answer this question, who can? This is no small problem today, one that ramifies far beyond the arcane realm of quality research methodology. In the 50 years since Donabedian sounded his alarm, the inflation-adjusted per capita cost of health care in the United States has increased by nearly 700%. It's tempting to think that the quality of care has kept pace with its skyrocketing cost, but in fact no one knows whether the "value" (quality relative to cost) of U.S. health care today is better or worse than it was a half-century ago. This astonishing fact might not shock Donabedian, who knew how hard it is to quantify quality. But it means that sensible suggestions to reduce cost cannot gain traction because we don't know how much, if at all, they might simultaneously reduce quality.[3-6] In theory, cost-effectiveness research is the answer to the "value question" but it can't succeed without public consensus about its "meaning" (how many people know, or care, what a QALY is?) and the political will to act on it.[7,8]

What to do?

Janice and I leave without waiting for the x-ray result, antibiotic prescription in hand. We're told we can buy the pills at the clinic, but somehow that doesn't feel right — among other things, they don't accept insurance — so we go to the local pharmacy. At the CVS, the recent merger is all the rage, with signs announcing better bargains for Aetna patients, and somehow that doesn't feel right, either. More than 10,000 retail clinics operate in the United States today and the new CVS–Aetna deal will probably double that number.[9] Will it also double the number of profligate prescriptions — not just for chest colds but for pain and anxiety and insomnia, too?[10,11] Optimists think not, hopeful that this vast expansion of retail clinics will be "a positive disruptor" that creates "a virtual comprehensive 'system' as a point of connectivity and care coordination."[12] *(Seriously? This is how we will achieve a health care "system" worthy of the name?)* But even enthusiasts for this "new model" admit that "in addition to short-term market and investor gains . . . ultimate success will depend on ensuring highest-quality care." Ah, yes. And we will know we've ensured that how, exactly?

But one fact is indisputable: the business opportunity is enormous. Ambulatory care accounts for 42% of U.S. health care spending, a trillion-dollar-plus market, larger than the national economy of all but a dozen countries, not to mention Apple.[3] Little wonder the Wall Street types are pouncing (CVS and Aetna, Walgreens and Cigna, Walmart and Humana . . .). Consider Janice's clinic visit, which cost $280, not including the x-ray. "High-value" care?[13] You decide. Even if the doctor spent twice as much time doing documentation as she spent with us (5 minutes, tops), her clinic can generate professional billing fees at an hourly rate that rivals that of Paul Manafort's lawyers. And as these for-profit clinics proliferate, staffed primarily by midlevel providers — the lower-cost staffing model is essential to the business plan — will they reduce their professional fees accordingly?[14,15] You know, to improve the value of U.S. health care?

A few days later, Janice's cold is better — she's pretty sure it's the antibiotic — but now, of course, I've got it, too. Lying low, I've been learning about the new Amazon–Berkshire Hathaway–J.P. Morgan deal. Warren Buffett, who says health care spending is "a tapeworm on the economic system," thinks this new "perfect partnership with Jeff and Jamie" will cut health care costs for their employees and "also deliver better care" (whatever that means).[16] But all cynicism aside about who's parasitizing whom, it's hard to argue with Buffett's basic beef: the government, he says, isn't helping these days, so why not give the private sector a shot? And hey, you never know: they've hired a CEO who's a "quality guy," a disciple of Donabedian who likes doctor-coaching, too.[17] So I figure I'll write the guy a letter, volunteer to help. Like Janice said about her antibiotic, it can't hurt to try, right?

But first I gotta get rid of this damn cough.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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