Correspondence and Clarifications

What Qualities Define an Expert Family Doctor? The Patients Have Our Backs

Editor's note: *We recently published an editorial (Unger J: What Qualities Define an Expert Family Doctor?* Clinical Diabetes *31:145–147, 2013) that garnered great interest among our readers. Following are two pieces of correspondence we received through the feedback section of our website (http://clinical.diabetesjournals.org/feedback), as well as a response from the author of the editorial.*

Feedback:

As an internist in private practice now for 35 years, I enjoy reading your updates in *Clinical Diabetes*. However, I felt I wanted to provide feedback on the editorial by Jeff Unger, MD. Anyone who ends an article with "Expert clinicians should remind their terminally ill patients that death is the penalty we all pay for the privilege of life" [should not be] entitled to provide your editorial comments. His comments to a patient with stage 2 pancreatic cancer and to his family that they were going to eliminate this aggressive tumor from his body is not an honest way to take

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his patient and [the patient's] family on their life's journey.

—Robert von Rueden, MD

In regard to the second example [included in Dr. Unger's editorial] of the individual with prostate cancer, I was extremely disappointed to see that Dr. Unger took what was said without reservation. The individual did not seem to know the name of the doctor who was the patient's primary physician. There probably is much more to this story, and I highly doubt it went down as described. This appears to be a very good example of "jousting," as the physician has been judged and determined to be guilty without any input from that physician. There was no call made to that physician and no question [asked] of the highly emotional relative. After 36 years in practice as an internal medicine physician, I am sure there was some misinterpretation of the comments. The above example is not representative of an expert family doctor.

—Anthony Tormey, MD

Author response:

I believe that health care providers should always "have the patient's back." Cancer, like diabetes, is *not* a terminal disease, but rather a chronic disorder that demonstrates a variable course based on intensification and timeliness of treatment, nutrition and emotional status, metabolic stability, and genetics. My patient with pancreatic cancer was referred to a clinical trials protocol the primary objective of which was to "eliminate the tumor." In fact, the tumor was not detectable before [the patient's] death.

I consider the additional 18 months of life that the patient experienced to be a true blessing, as did his family. I therefore disagree with Dr. von Rueden, who implies that a clinician should not be entitled to suggest to a family that pancreatic cancer can be cured. The family, patient, radiologist, and oncologists saw absolutely no evidence of tumor in this patient's body at the time of his death. I kept *my* promise.

My father-in-law met a similar fate and succumbed to pancreatic cancer just before the death of the patient I described in my editorial. His last meal was a large bowl of vanilla ice cream. "Papa" had type 2 diabetes; the nurses were always berating him for eating foods that could "make him sicker." During one of his hospital stays, he was placed on an "ADA 1,800-calorie diet" by his internist. Breaking protocol, I purchased a cup of ice cream for Papa in the cafeteria and advised him to hide it from the nurses so he would not get in trouble. Too late! When the charge nurse ran into the room due to a disconnected cardiac monitor lead, she yelled, "Where did you get that ice cream . . . *sir*?" Papa quickly replied, "It must have been here when I got to the room yesterday!" One month later, at his home, he asked once again for vanilla ice cream, because he was hungry and emaciated. There was no need to check his blood glucose. He appeared to be enjoying the ice cream as Grandma slowly fed him each bite until the bowl was finished. He died 15 minutes later. At his funeral outside of New York City, the mourners' tears morphed into smiles when, out of nowhere, the musical sounds of a Good Humor ice cream truck engulfed the grave site. No ice cream trucks were reported to be anywhere near the cemetery that day. Papa had our backs.

Last week, I saw a 62-year-old patient with newly diagnosed type 2 diabetes for his initial visit. The patient was concerned. He told me his other doctor said his A1C of 8.9% was "a little high" but should come down with "diet and exercise." Dr. Tormey's comment suggests that I should not take this patient at his word, but instead should call his other provider to validate his claim. Nonsense!

My new patient was a pastor of a small local church. After doing the routine diabetes intake and physical exam and initiating an intensive diabetes protocol for the pastor, we spoke about the relationship between spirituality and medical outcomes. The pastor felt pleased with his new physician and was prepared to embark on a comprehensive diabetes self-management program.

As the pastor was leaving the office, I spotted David sitting in a wheelchair in my busy lobby. David not only has diabetes, but also has suffered multiple devastating orthopedic injuries in the past 3 years. I asked the pastor to say a prayer for David as he waited in the lobby. Not only did he hug and pray for David (a person whom he had never met), but he also prayed for the health of everyone else in the lobby—even the pharmaceutical reps. I have never seen a happier group of people in a single afternoon in my 30-year career.

Expert clinicians help their patients heal emotionally, spiritually, and physically. In a perfect world, clinicians should have the backs of their patients. When they do, the patients will support their health care providers and have their backs, as well.

—Jeff Unger, MD