

vice basis and the patient has open-ended insurance, the scales are tipped in favor of doing as much as possible and against limiting interventions to those that are cost-effective. In that setting, who would benefit from the resources that are saved by practicing cost-effective medicine is not obvious to the physician.

In contrast, if the physician is practicing in a setting that has accepted responsibility for the health of a defined population and the organization receives an annual fee per enrollee, the chances of the physician's practicing cost-effective medicine are substantially increased, even though all pa-

tients are insured. The physician's colleagues are practicing the same way, and the resources saved can be used for the benefit of the defined population, which includes the physician's patient. In Canada, which has universal insurance, per capita spending on health care is only 55% of the U.S. level because there is a limited overall budget, and all physicians in the system recognize the need for prudence in making decisions about care.

In short, when physicians are collectively caring for a defined population within a fixed annual budget, it is easier for the individual physician to resolve the

dilemma in favor of cost-effective medicine. That becomes “appropriate” care. And it is an ethical choice, as defined by philosopher Immanuel Kant, because if all physicians act the same way, all patients benefit.²

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Complicated Lives — Taking the Social History

Ranjana Srivastava, F.R.A.C.P.

Traditionally, as I recently taught medical students on their first hospital rounds, the medical history consisted of the history of the present illness, followed by previous history, drugs, and allergies. Buried somewhere in there, usually after allergies and before examination findings, was the social history.

As a medical student 20 years ago, I was taught to ask three questions to elicit the social history: “Do you work?,” “Are you single or married?,” and “Do you smoke or drink?” If you knew these three answers, you could avoid an examiner's further scrutiny — an easy path to a good grade.

Ten years later when I was taking my fellowship exam, the bar was higher. Common wisdom held that even a “bad patient” could be salvaged with a good social history, which now extended to asking about stairs to the

patient's house, the amount of his or her pension, and who did the grocery shopping. “Bad patient,” of course, referred not to personality but to the dreaded patient with a rare syndrome and tricky clinical findings who appeared each year for the express purpose of stumping anxious fellowship candidates.

Recognizing the value of a good social history, my colleagues and I became experts at taking one in record time by multitasking. I would tap on a patient's ankle to elicit an obstinate reflex while asking, “Does your pension cover the cost of your pills?” or dig my fingers to find the spleen while mumbling, “Have you ever been depressed?” It felt inappropriate, but every candidate knew that you could talk to your heart's content about poor Mrs. Smith, dependent on a wheelchair and waiting for public housing, but if you ignored the facial

palsy, misheard the mitral stenosis, or misjudged the hepatomegaly, you would be retaking your exam next year. So the social history remained at the bottom of the hierarchy.

Having taught the medical students, I return to clinic, thankful to no longer be subjected to the hawkish gaze of an examiner.

My first patient is a 70-year-old woman who seems disheveled and distracted. She's receiving chemotherapy, and I assume she's due for another cycle. Other clinic doctors have seen her before, but I haven't.

“How are you?” I greet her.

The computer screen nearly obscures her shrug.

“I don't know.”

“How do you feel?” I open her electronic record.

She starts crying.

I wait. Tearful patients are not unusual in an oncology clinic.

“Any issues with the chemotherapy?” I ask sympathetically.

She sobs, “I don’t know, I don’t know.”

With this, her fragile composure breaks. She wrings her soggy tissues as I look around for more. Apologetically, I hand her some paper towels before returning to hammer the keyboard for some information. Why this meltdown? Does she have a psychiatric history?

Every page I flick to, there are chemotherapy orders, x-ray results, and blood tests. There’s also correspondence about her cancer, meticulous summaries of her progress, right down to the number of laxatives she needs. But I can’t find anything giving me a clue to her tears. I am flummoxed. Each time I open my mouth, her distress becomes more pronounced. Is it me, I wonder? What did I do? The clock ticks, and soon the secretary knocks on the door to ask how much longer I will be.

Feeling criminal, I’m forced to speak through the patient’s sobs.

“Can I sit you down next door with a coffee and bring you back in a while?”

“Never send me there!” she wails. “Even if I’m really sick.”

“Send you where?” I ask, puzzled.

She shakes her head violently.

I think of calling a nurse to help. But what would I say to her? “Can you calm my crying patient?”

I try one more time. “I may be able to help if I know what the matter is.”

Momentarily, her tears stop. She asks incredulously, “The matter? The matter? Didn’t they tell you?”

“No, I have no idea!” I respond,

immeasurably relieved to simply have her talk.

“My husband, he died from cancer last week. He died in that hospice of yours.”

The recollection sends her into a fresh burst of tears.

“I am so sorry.”

She holds my gaze. “Didn’t you know?”

“I had no idea,” I say softly. “I really had no idea.”

There is complete disbelief in her expression.

Distressed and probably disgusted, she nevertheless allows me to walk her out. A nurse takes her hand, and I return to my office. Afterward, the nurse returns. “Poor thing, his death was hard on her. He was sick for so long.”

“How do *you* know?” I ask, sounding unintentionally plaintive.

She looks at me curiously. “Because I talk to her.”

Feeling even smaller for not having known the patient’s husband was ill, let alone that he had died of cancer in this very hospital, I return to her file. Surely somewhere there’s a mention of her sick husband that will allow me to take the blame for not reading more carefully. But the closest I come is a note written by an intern some years ago: “Married, husband runs plumbing business. Two children, supportive. Nonsmoker, minimal alcohol.”

Nothing has changed in all these years, I think wryly. Social history is often treated as an optional extra, relegated to the social worker in case of real need. Eliciting the modern social history generates a whole new set of challenges for doctors. Take the terms “husband” and “wife.” One couple looks awkward when referred to that way, whereas another woman ex-

claims, “Spare us the ‘partner’ nonsense — we’ve been married 40 years!” The man accompanying a boy to an appointment could be his father, his stepfather, or his mother’s new partner. It takes sensitive questioning to find out. In addition to establishing whether a patient has a smoking or alcohol habit, it’s increasingly necessary to inquire about illicit-drug use and sexual history, though the task is uncomfortable for many doctors and patients. But our patients provide us glimpses of their social history and expect us to respond whether we like it or not.

I have a patient whose demented husband no longer recognizes her. She has stopped visiting his nursing home and has moved in with a male friend. She is angered when anyone assumes that this friend is her husband. She rightly expects her private life to be sacrosanct, but she also wants our acknowledgment that she was a devoted wife and that it’s OK for her to live with someone else. Another patient is divorced but lives happily with her former in-laws. “Her disease is stable,” her mother-in-law says cheerily. “It’s our son who’s not.”

So how does a modern health service come to terms with the modern social history? Now that jotting down the number of cigarettes smoked or the patient’s marital status is clearly no longer sufficient, I think we need to teach young doctors to regard the social history through a wider lens. Our social networks may appear to be larger these days, but they’re increasingly virtual and fragile. Facebook friends seldom appear at the bedside with magazines or flowers. Twitter is no match for real conversation.

So to truly gauge their level of social support, we must ask patients about their lives carefully and sensitively. We must document what they tell us, and be mindful of it in our consultations. As people live longer, their social situation becomes more fluid; it deserves the same attention as their disease status.

Taking a comprehensive social history is time-consuming. It's easy to dismiss the task as outside the doctor's purview, espe-

cially when there's precious little time to get through a sea of investigations and treatment options. But every patient is a person, and illness occurs in the context of multifaceted lives. We need to listen to our patients with the recognition that the most important information they can give us about their illness often lies in the folds of their social circumstances. And it's our obligation to tailor our prescriptions to an illness in its full context.

Until we teach doctors that social history is more than a tool for passing exams, we will be practicing piecemeal medicine that leaves us all with a whiff of dissatisfaction. Taking a good social history may be no one's job, but it's everyone's responsibility.

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