

LESS IS MORE

First “More,” Then “Less”

AS A FAMILY PHYSICIAN FROM THE NETHERLANDS, I work as a gatekeeper in a setting with a long-standing tradition of supporting strong primary care by both the public and policymakers. The concept that less can be more is one of the pillars of the cost-effectiveness of the Dutch health care organization.¹

My experience with this concept is that before “less is more” comes into play, initially “more” is needed. This “more” deals with time invested in the patient-physician relationship.² In this process, I will come to understand my patient in the context of his life (family, work, social activities, health behavior) and he can learn whether my practice is of good quality or not. If all works out well, we establish a relationship based on trust.

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I will exemplify what I mean by describing patient K, a 45-year-old man who, at that time, was just listed in my practice. He was married, with 2 children, ages 5 and 7 years. From his previous physician, he was used to getting antibiotics when he had a sore throat, and so he came to ask me for a prescription. He’d had the pain for 3 days; paracetamol did not help; he was worried about infection, and he knew from his previous experiences that antibiotics would help him. On physical examination, I found no fever and no abnormal swelling of lymph nodes in the neck region. On inspection of the oral cavity, I found a reddish pharynx. My conclusion was that he had a viral pharyngitis.

I told him that, in my view, antibiotics would not be helpful. I explained to him about bacterial and viral infections and asked him what was most important: to get the antibiotic or to get rid of the pain. He told me that the pain was his biggest problem and that antibiotics had helped him many times before. I invited him to do an experiment: to use a prescribed painkiller (ibuprofen, 600 mg, 3 times per day) instead of antibiotics. As a safety net, we would make 2 follow-up appointments with me, in 2 and 4 days. He agreed. After 2 days, he told me that the painkiller had worked well; at day 4, he felt better

and stopped using the medication. In both consultations, we talked about the healing power of the body, the natural course of common disease, and about his worries of keeping his job. He positively evaluated the course of this episode.

In the years following, I have seen him and his family members on several occasions but not for sore throat. Neither he nor his wife has ever asked for antibiotics again; instead, they told me what their symptoms were, and they asked for relief or advice.

The initial investment—three 10-minute consultations for a common sore throat—seems disproportionate and was not required according to the guideline of the Dutch College of Family Physicians on acute sore throat.³ However, in the long run, I was ultimately able to practice “less is more,” and not only for 1 patient but for his entire family. The ongoing challenge of the medical profession is to show policymakers that these mechanisms exist and that they are cost-effective.

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