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A day in the safety net

5:30 A.M. Home.
Mr. Hernandez wakes up excited and enthusiastic because last night his neighbor's friend told him about our community clinic and encouraged him to seek help there for his medical problems.

5:50 A.M. Bus stop.
Boards the bus at 6:00 A.M., travels downtown, then transfers to another bus. He finally reaches our clinic at 7:15 A.M.

7:30 A.M. Triage.
The clerk tells him to get a "red card" (one day /one visit card) from the cashier window in order to be seen by the triage physician today.

8:00 A.M. Cashier window.
The cashier asks Mr. Hernandez to pay $30 for the facility and expect a bill for the physician service later. He says he has only $10 in his wallet. "Sir, you need to go to the administration to discuss this matter with them."

8:30 AM. Administration office.
After a short discussion, the administrator grants Mr. Hernandez a waiver, if he promises to pay $20 next time he comes to the clinic.

9:00 A.M. Back to triage.
The clerk allows him to register, and the nurse takes his vital signs: BP 160/90. He reports no chest pain or shortness of breath, so he is sent to the waiting room.

9:05 A.M. Waiting room.
As he enters the small area, almost full, he scans the room and notices in the far corner an empty space. He squeezes in, looks around, and counts: there are 10 patients waiting their turn before him. At almost every minute a loudspeaker makes an announcement or calls a patient.

11:00 A.M. Exam room.
Mr. Hernandez and I finally meet. He is a 49-year-old Latin American man living in Houston for the past 20 years. He used to work in construction and landscaping, but last year he had an accident that left him with chronic back pain after 2 back surgeries. He says that he cannot work hard as in the past. He also suffers from long-standing diabetes mellitus type 2, hypertension, and high cholesterol.

11:30 A.M.
Again in the Administration office.
After another humiliating conversation, the administrator grants Mr. Hernandez another waiver.

11:45 A.M. Lab.
Blood drawn.

12:00 P.M. Back to the waiting room.
Mr. Hernandez feels restless and hungry. He sees vending machines close by, but the cashier has all his money. He had expected to by home by lunchtime.

12:50 P.M. Again in the exam room.
Lab results are back; I counsel him and give him his prescriptions. I instruct him to return to the administration office before proceeding to the pharmacy.

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1:00 P.M. Administration office.
For the 3rd time he has to clear them from the office, with always the promise to pay the bill later.

1:15 P.M. Pharmacy window.
"Waiting time is 2 to 3 hours," the clerk tells him. He takes a seat in the pharmacy waiting room.

3:50 P.M. Pharmacy.
The clerk calls him to the window and gives him his medications, but for only a 30-day supply, without refill.

4:00 P.M. I see Mr. Hernandez leaving.
He looks exhausted and hungry. With a dry tongue and a hopeless voice, he says "Doc, they didn't give me a the follow-up visit you recommended to check if these medications are working. Instead they told me to go to the eligibility center to apply for Gold Card (a permanent card) and bring it with me next visit. I don't know how to get to this office and I can't provide them all the documents they are requesting. I don't know what I will do next. Anyway, thanks Doc."

After a 30-second pause, I said, "Come back if you need help, even if you don't have the Gold Card." He looks at me with a worried frustrated face and says, "It has been a long and humiliating day, and I don't know when I will have the courage to repeat that experience again. Hasta luego and muchas gracias."

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Evidence-based medicine ratings

THE JOURNAL OF FAMILY PRACTICE uses a simplified rating system called the Strength of Recommendation Taxonomy (SORT). More detailed information can be found in the February 2003 issue, "Simplifying the language of patient care," pages 111–120.

Strength of Recommendation (SOR) ratings are given for key recommendations for readers. SORs should be based on the highest-quality evidence available.

- **A** Recommendation based on consistent and good-quality patient–oriented evidence.
- **B** Recommendation based on inconsistent or limited-quality patient-oriented evidence.
- **C** Recommendation based on consensus, usual practice, opinion, disease-oriented evidence, or case series for studies of diagnosis, treatment, prevention, or screening

Levels of evidence determine whether a study measuring patient-oriented outcomes is of good or limited quality, and whether the results are consistent or inconsistent between studies.

STUDY QUALITY

1—Good-quality, patient-oriented evidence (eg, validated clinical decision rules, systematic reviews and meta-analyses of randomized controlled trials [RCTs] with consistent results, high-quality RCTs, or diagnostic cohort studies)

2—Lower-quality patient-oriented evidence (eg, unvalidated clinical decision rules, lower-quality clinical trials, retrospective cohort studies, case control studies, case series)

3—Other evidence (eg, consensus guidelines, usual practice, opinion, case series for studies of diagnosis, treatment, prevention, or screening)

Consistency across studies

Consistent—Most studies found similar or at least coherent conclusions (coherence means that differences are explainable); *or* If high-quality and up-to-date systematic reviews or meta-analyses exist, they support the recommendation

Inconsistent—Considerable variation among study findings and lack of coherence; *or* If high-quality and up-to-date systematic reviews or meta-analyses exist, they do not find consistent evidence in favor of the recommendation