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FINANCIAL INCENTIVES AS AN UNEXPECTED PATH TO WHOLE PERSON CARE

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Most of us who enter medicine do so with pure intentions of helping one another, of being of service to our fellow humans. Most of the time, this noble aim is achieved. However, in 2018, I sat in a buprenorphine waiver class with a simple, self-serving objective: I wanted to earn an additional financial stipend. I know, not terribly service minded – unbeknownst to me, I wouldn't remain in this rather callous disposition for long.

I listened to the clinical vignettes, the social determinants of health and holistic care required in treating those with substance use disorder. I started to see similarities with my palliative medicine practice, where there is an emphasis on whole person treatment and physical, spiritual and mental health all intersect.

I began to question the division of substance use disorder from other chronic progressive illnesses, such as COPD, CHF, diabetes, and even cancer. Similar to addiction and substance use disorder, living with any one of these diseases involves an ongoing, repeated cycle of exacerbation and, hopefully, stabilization. Opening myself up to really listen, to remain curious, to walk with patients on their journey, highlighted more similarities between *all* diseases, than differences. I began to see the necessity of putting my palliative care

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mantra, of holding the patient-physician relationship at the pinnacle of all that is said and done, into practice with this new patient population, as well.

A male in his mid-60s presented to clinic after stabilizing from inhaled substance abuse. He found me on the federal substance abuse and mental health website of buprenorphine providers. I approached with curiosity and our initial conversation went something like this.

When was the first use?

“As a teen on and off. At 13, I started drinking alcohol. My dad drank. It’s what I knew. But one time, my dad had to bail me out of jail, and he told me ‘stay at home and drink, if you’re going to do it.’”

Did your family also use substances?

“Just my dad. I have two sisters and they did not use any substances. They died of cancer.”

Were you trying to escape or medicate yourself with these substances?

“Not at first. Running around in a group, and that’s what we did: drank hard, fought hard and drank again.”

How did your use evolve to other substances?

“Somebody asked me to do something, and I did it. I was 27 when I started using cocaine. It was a social thing a few times a week. I had back surgeries. I was given narcotics. I would go from one doctor’s office to the next. I used the pain meds mainly for pain, but also for getting high. I never used IV, just snorted.”

What support do you have in your life now? Are you living in a safe place?

“In 2015, my wife was murdered by her drug dealer. In 2018, my best friend died of lung cancer, and I live with his wife now. She has two rules to live there: no drug use and no overnight guests of the opposite sex.”

Since leaving drug rehab, this patient had a sponsor within a dual-dependent alcohol anonymous (AA) program, with whom he speaks regularly. He attends AA meetings. He feels a purpose outside of himself to help keep up the house and yard for his deceased friend’s wife.

– Then COVID –

Visits converted to video and telephone. We saw one another every couple of weeks. He attended AA meetings virtually. He engaged with his sponsor.

– Then trauma –

He fell and broke his femur. Surgery ensued, followed by physical therapy and rehab. I followed closely after hospital discharge and provided pain management with buprenorphine and support via virtual visits to the rehabilitation center.

However, this trauma had changed his life forever. Eight months later, he struggled to walk and was unable to navigate stairs or drive – making it nearly impossible for him to join his preferred, in-person AA meetings.

This patient was suffering. He began asking for more buprenorphine. I requested an in-person visit and urine drug screening. He presented to my office in a wheelchair and barely recognizable, with deep circles under his eyes, extremely prominent cheekbones, and a huge loss of muscle mass in all extremities. He hung his head. He couldn't look me in the eye.

"I've been using," he said. I allowed for silence. I nodded my head in affirmation and waited. Then he responded in anger. "I am an addict! This is what I do! I guess you're not going to see me anymore?"

– Then space –

I took his hands in mine. My next words would be the most important in the trajectory of our patient-physician relationship.

"You are my patient, and you are struggling. When you are struggling, we walk more closely together. We see one another more often. We journey closely together until you find stability again. You have found space and ability to live a sober and thriving life, I believe you can do that again. We'll do this work together."

He sat, stunned. He looked-up, for the first time in the visit. Silence passed. And a whispered, "thank you" hung in the air.

This space allowed for his story to be told – he was visited "by an old friend" in the hospital. He purchased illicit Xanax while in the hospital. He continued to use benzodiazepines and opioids supplied by outside friends in addition to his treatment plans created by myself and orthopedic surgery. He shared the financial checks he was bouncing, the shame he was feeling and the overwhelming sense that he was alone. Until this visit.

We devised a plan for weekly in-person visits, more frequent urine testing, increased conversations with his AA sponsor and initiation in the local county's certified peer specialist program.

He found creative and meaningful ways to contribute to household chores and his family. He lived with purpose until his eventual death from a complicated, but expected, array of comorbidities, including pneumonia, kidney failure and protein calorie malnutrition. He had remained sober for the rest of his life.

As for my story, a financial incentive and an unexpected therapeutic relationship opened my heart and expanded my perspective, bringing me back to my *Why?*, and the deep honor I find in service. ■

Biographical note

Michelle Goetz is a palliative medicine physician, internist and addiction medicine specialist providing care in the multi-state Mercy healthcare system. She serves in Mercy leadership roles closely supporting primary care physicians in primary palliative skills, specifically around advance care planning. Michelle is inspired to share her passion for ensuring patients receive the right medicine at the right time and are empowered

on their journeys with serious illness. She is married with three young daughters and loves hiking, running, and reading.