

## *Editorial*

# The care of the patient

Richard L. Byyny, MD

**D**r. Henry Kempe, author of the seminal “The Battered-Child Syndrome,” was a professor of Pediatrics and Microbiology and chairman of the Department of Pediatrics at the University of Colorado from 1956 to 1980. In 1978, he finished a hectic and busy day of work, grabbed a full suitcase and a heavy briefcase, and caught a flight to New York to receive the Aldrich Award of the American Academy of Pediatrics for contributions in the field of child development. He arrived at his hotel that evening, exhausted by the long day and travel. Shortly thereafter, he developed shortness of breath and hemoptysis. He called a colleague at NYU, who advised him to go to the ER at Bellevue Hospital; he took a cab to the emergency room and was admitted to the coronary care unit, where they fortunately had an open bed, in cardiogenic shock from an acute myocardial infarction with pulmonary edema. He was intubated and on a respirator, and had a balloon pump inserted in his aorta to assist in maintenance of his blood pressure.

With no recollection of his first two weeks in the coronary care unit, Dr. Kempe gradually awakened to pain and confusion. He continued to be very confused and sleep deprived by all that was going on in the unit, and was, in addition, fearful about his memory and reasoning losses and the delusions and frightening hallucinations he experienced. The only good thing about the unit was the nursing staff. They held his hands, bathed him, oriented him by looking him in the eye to tell him his name, his situation, and where he was and what day and time it was. The personal contact was comforting and caring. The nurses assured him that he would regain his sanity

and that the “scary dreams” would resolve.

Two or more times a day his doctor and other physicians would make rounds. Dr. Kempe saw them as being like a school of sharks who would swim in, look at his chart, and watch the multiple monitors without talking to him, looking him in the face, or touching or comforting him. He watched them attentively to try to gain clues about whether he was getting better or worse: did they frown, grimace, shake their heads up or down, or yes or no? They would then swim out with his chart in hand.

One day, a few days after his balloon pump had been removed, he awoke frightened and crying. He could hear a loud pulsating sound. He was still intubated, so could not ask questions, but deduced that the balloon pump must have been reinserted indicating that he was worse. His nurse could see his disturbance. She asked, “Is the sound you’re hearing disturbing you?” She looked at him, held his hand, and said, “That is the wrecking ball knocking down the rest of the old Bellevue Hospital. You didn’t hear the noise on Saturday and Sunday, but you did hear it on Friday when your aortic balloon came out. That was a bad time. You remember not only how painful that was, but you also remember how the balloon sounded inside you during those rough days. I bet you are remembering that pain.” With her care and thoughtful reasoning about why he was suffering, and with her explanation, his distress disappeared. He gradually had fewer flashbacks—when he did the nurses would comfort and care for him. The nurses continued to support him with the intuition to understand his responses and distress to almost any change and to provide the needed

care and support. In due time he was discharged and returned to work as a doctor, scholar, and teacher.

Dr. Kempe told this story to our General Internal Medicine Residency fellows while I was residency director, but found it too difficult and disturbing to relate it more than once. *The Pharos* published his article about the experience in the Winter 1979 issue (“Nursing in a coronary care unit: A doctor-patient’s view, pp. 18-19”), in which he included a footnote about the thirty-six physicians and surgeons involved in his care and his gratitude to them. No doubt many of the decisions made by the physicians were important in his successful outcome for which he was appropriately thankful and appreciative, but I am pretty certain that none of them were aware of his perception of their inability to understand his suffering and care for him. What he described was his need—as the patient—for caring by physicians.

Dr. Francis W. Peabody wrote in 1927 that “one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is *caring* for the patient.” For me, the doctor-patient relationship and the care of the patient in the office or hospital represent the best in medicine. Serving as a physician has continued to be rewarding professionally and personally gratifying. It has remained true that successfully and effectively caring for patients is more than the application of science and technology. Caring for the patient is much more than treating a disease, illness, or injury. It includes—as AΩA’s motto proclaims—that we “Be worthy to serve the suffering.” Suffering may be primarily related to a disease in some patients and using specific and effective treatment may relieve most of the suffering, but many times there isn’t an effective, certain, or rapid intervention for the patient. Even when we are uncertain about the diagnosis or effectiveness of our treatment, caring for the patient and the relief of suffering is paramount.

Many changes in society and medicine have made it more difficult to care for and serve the suffering. Dr. Joe Marr described many of them in his article, “Fall from Grace,” in the Winter 2014 issue of *The Pharos*. These include: the rising cost of care; fee for service care; reliance on technology as a substitute for clinical judgment; organizational interference in the physician-patient relationship; the focus on patient visits per unit time rather than the care of patients and outcomes; the concept of profit and loss centers in medicine; billing and collection terminology; overuse and underuse of technology; development of cumbersome bureaucracies; for-profit hospitals; for-profit insurance companies with a focus on quarterly earnings; the use of non-physician employees to determine patient eligibility for care; the use of claims adjusters; the businesses and companies that set the rules of care; the use of

euphemisms in medicine, in which a doctor becomes a “health care provider” providing “services” to a “client,” “consumer,” “customer,” or “stakeholder”—anything but a patient; coding of conditions so that GERD is code 530.81; and others. George Carlin in one of his routines said, “When I was a little kid, if I got sick they wanted me to go to the hospital and see the doctor. Now they want me to go to a health maintenance organization or a wellness center to consult a healthcare delivery professional.”

Medicine is now often perceived as a business rather than as a profession. Profit, business practices, business principles, and business strategies, rather than the care of patients, too often determine the care or lack of care for people. Sir William Osler’s maxim, “The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head,” is being lost.

I gave a lecture a few years ago to community physicians who were mostly in their 50s and 60s. Over dinner most of the conversations and discussions were about how practicing medicine and caring for patients had become more difficult and less satisfying professionally. Across from me was a younger woman who was not participating in the discussion. I leaned forward to engage her in the conversation and asked, “What do think about our conversation and the practice of medicine?” Her response was, “I don’t remember the good old days. I cherish my time caring for my patients and they seem to appreciate and benefit from my care and my team’s thoughtful caring. I have learned to fill out the required forms, make the necessary calls, and deal with the nonmedical management required.” Shortly thereafter, I spoke with a retiring physician executive from the Mayo Clinic, who acknowledged that managing a large hospital and clinic was no longer fun nor particularly professionally rewarding, but he noted that there were exceptional younger physicians capable of enthusiastically and competently leading and managing the care of the patients. One’s past experiences and context are important to our perception of medicine and our professional satisfaction with medicine.

Despite the developing elements in the care of patients, how we care for patients continues to be our most important professional responsibility. The care of the patient continues to be based on what the patient needs and what is most important for the patient and his or her illness and suffering. The qualities that a physician needs to do this job are many, but foremost is being present and engaged with the patient. Think about it. The doctor-patient relationship is at the foundation of our medical profession.

E-mail Dr. Byyny at [r.byyny@alphaomegaalpha.org](mailto:r.byyny@alphaomegaalpha.org)