How Can “Caring for the Patient” Improve Healthcare?

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"There are moments, of course, in cases of serious illness when you will think solely of the disease and its treatment; but when the corner is turned and the immediate crisis is passed, you must give your attention to the patient…The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, ***for the secret of the care of the patient is in caring for the patient."***

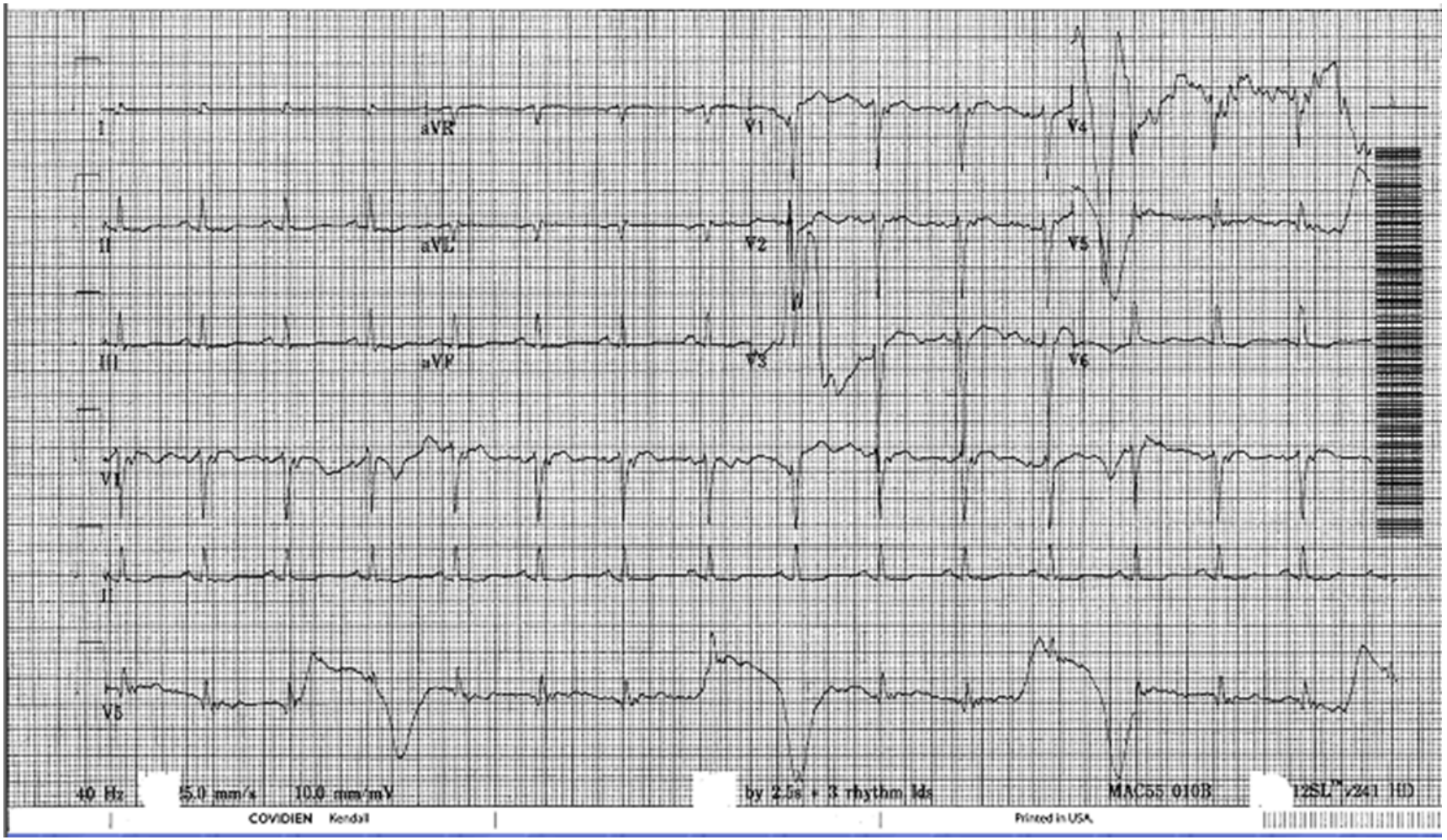
- (italics and bold added; part of a series of lectures to Harvard medical students in the mid-1920's)
- JAMA. 1927;88(12):877-882.

A Case example

- Pt new to us, 67 years old, seen for first time in our office. Multiple past admissions recently to RUMC
- In office: SOB, low Pox – 45% to 60% initially on his home O2; improved to mid-80's on our O2 in office
- Sent by ambulance to ED

What's a quick differential?

Pt's EKG


I
aVR
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III
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40 Hz
5.0 mm/s
10.0 mm/mV
by 2.5s + 3 rhythm 1ds
MAC55 010B
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Imaging and lab data

- CXR:Marked hyperlucency of the upper lobes consistent with severe emphysema again noted. Coarse reticular pattern in the right base grossly unchanged from before. No evidence of a new superimposed infiltrate. Heart magnified by the technique.
- BNP 4050 initially
- Troponins avg 0.134 – 0.136 initially, steadily decreased

Other info

- Pt had been on Digoxin and diuretics for CHF
- Pt now stabilizing on tele floor. Cardiology consult called. Echo on this admission shows 40% EF amongst other findings, apparently improved from last echo 7/2018 (see below).
- By comparison: Echocardiogram 7/2018: "Severe LV systolic dysfunction. There is severe global LV hypokinesis. The estimated LV ejection fraction is about 20-25%. There is a pseudonormal LV filling pattern consistent with moderate diastolic dysfunction (Grade 2). There is mild left ventricular hypertrophy. There is mild right ventricular hypertrophy. There is severe right ventricular systolic dysfunction. There is mild mitral regurgitation. There is mild tricuspid regurgitation. The estimated RV systolic pressure is 47 mmHg."
- Venous duplex negative for DVT

Pt review in the chart

- RUMC records with Cardiology's assistance show PMH of HFrEF s/p AICD, atrial fibrillation (supposed to be on Xarelto), COPD, mild pulmonary HTN (RV 47 mmHg), BPH with urinary retention (previously requiring indwelling Foley, recently removed), with multiple hospitalizations (6 in the past 6 months for shortness of breath).

- PMHx/PSHx: as above
- FHx: noncontributory
- SHx: former smoker; denies alcohol use; former cocaine user

What people in this hospital were telling me about him before I even saw him

- “He’s a repeat offender around here – we know him well”
- “He’s noncompliant”
- “He just doesn’t listen – that’s why he keeps coming back”
- “He’s a frequent flyer”

- We’ve ***all*** been there…thought that…

The Dx and Plan

- CHF/COPD mixed picture
- Mild Pulmonary HTN
- Started on Digoxin and Xarelto (pt had been on before); furosemide
- O2, nebs, prednisone
- Pt got better

The end???

Critical missing information

- Pt's home had burned down a few months before this admission
- He had been in the DHS shelter system until very recently when he was finally able to obtain housing.
- Pt has had inconsistent f/u for his chronic CHF and COPD as a result, as well as incomplete compliance with his med regimen.
- Further complicating matters is that pt is O2-dependent, but his O2 concentrator does not have enough battery life for him to travel far and thus he has not been able to keep any of his f/u appts with his specialists. Normal O2 at home at 3L NC. Max battery life between 2 and 3 hrs.
- His Cardiology and Pulmonary specialists were at least 40-60 minutes away by public transportation; let’s do the math…

The conclusion?

- Simply asking a few more questions and caring enough to help get simple things done like getting his O2 concentrator fixed/repaired could have prevented a majority of those admissions
  - He could make his appts
  - His O2 concentrator would work more consistently
  - He could have possibly gotten quicker help for his housing if it was known he had significant medical conditions
  - Since being discharged he only had one short admission over the following four months

The punchline

- This was a potentially preventable series of admissions.
- Caring, per Dr. Peabody's advice, could have saved everyone a lot of time and resources.
- We need to ask the right questions with the right attitude
- We need to ignore, for a short while, the financial bottom lines and excel spreadsheets which dominate medicine

Practical ways to help us care

- ***Make sure we are ok*** – if WE aren't doing ok, how can we possibly help anyone else to be ok? Communicate with each other, and get help if needed
- Depend on your core personal beliefs – you are stronger when your strength comes from outside yourself
- THEN figure out how to care for the patient from your own reserve, NOT a deficit – your patients can tell the difference

Practical questions to ask in order to create opportunities for “care”

- Do you have a safe place you can comfortably call “home” to go to?
- Do you have any legal issues which are impacting you that a lawyer could help you solve?
- Are you concerned about your ability to afford and buy good, healthy quality food for your family?
- Do you consider yourself a religious person? If so, do you attend weekly religious worship services of any type? If so, how frequently on average every month?
- If you do NOT consider yourself a religious person, do you consider yourself a spiritual person?
- Do you need to talk to a staff member about any of the above issues in a confidential manner? Are there any other concerns you would like to speak about to someone?

Concluding with Dr. Peabody again…

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