


Physicians as Caregivers: Beyond Standardization

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A patient presented to our tertiary care center's emergency department (ED) in early Fall with 2 days of generalized abdominal pain and loose stools. His physical examination was not requiring surgery, and I made an assessment of viral gastroenteritis. He was discharged with reassurance and supportive care instructions. I used a systematic method to gather his subjective history, interrogate objective information, formulate an assessment, and deliver a plan—the SOAP method, considered to be medicine's framework of documentation. Such a process of standardization is executed with every patient in order to provide accurate and appropriate medical services. Standardization in health care through the use of clinical algorithms has allowed clinicians to continuously synthesize and interpret large volumes of information effectively in order to provide the service of medicine to as many patients as possible in the same possible way. The patient in the ED was able to eat and drink, and his pain improved. He was considered safe for discharge home within the hour.

Having a systematic approach in place to see patients allows us to practice the bioethical principle of justice, defined as a form of fairness in the distribution of goods—in this case, time spent with a health care provider; it also allows us to uphold Nonmaleficence or the obligation to avoid inflicting harm on others (1), by providing the *standard* of care. Although I am early in my medical career, I am convinced that practicing medicine isn't just simply the act of rendering standardized medical services. Systematic care should complement the physician-patient relationship, specifically by encouraging us to venerate the uniqueness of each patient.

"How are you doing otherwise?" I asked him. "Good," he said, "but now I've been missing classes at school." Before his discharge, I provided him with a school excuse form.

Another patient encounter is the vaccine-hesitant family of 3 healthy siblings I have cared for at Danis Pediatrics, our institution's academic, urban primary care center. During every well-child visit, the parents presented reasons to delay

receiving immunizations, such as the widely recognized public misconceptions of vaccines causing Autism, and how "too many vaccines can overload their immune systems." They often reaffirmed that "we'll need to read more about them." For over a year, I offered the recommended vaccines (2), and for over a year, they declined. During a follow-up visit, they said "we'll get the shots today." Broaching the subject again had resulted in them agreeing to a catch-up vaccine schedule. Perseverance and cultivation of the physician-patient relationship resulted in the family being spared of vaccine-preventable diseases. Not to mention, my confidence as a clinician was nurtured. Shared decision-making (SDM) (3) between the patient and physician is central to the heart and art of medicine, and it has been shown to lead to improved patient satisfaction and less decisional conflict (4), as reflected in this encounter.

An opposing view is that clinicians may become jaded with patients who do not adhere to medical recommendations. For instance, a patient with diabetes neglects to take insulin as prescribed and later presents in diabetic ketoacidosis (DKA) or a patient stops taking a prescribed antibiotic because the burning sensation on urination "went away" after 3 days, only to present again the following week with similar symptoms. If viewed only in this light, patients may be seen as "not caring," about their health, about our recommendations, or both. The clinician may pay them back in their own coin, and the encounter may be short and not as fruitful as deserved. This becomes particularly true if our

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patients keep getting in the way of us providing checklist-directed patient care!

But to err is human, and our frame of reference changes as we reflect on the patient's perspective and discover something that can't be found in a list of items, and thus, we may avoid becoming jaded.

In other words, caring.

A distinction should be made between empathy and caring. Whereas empathy may be described as the act of correctly acknowledging the emotional state of another without experiencing that state oneself (5), caring about patients places clinicians on a different platform, one on which we should feel compelled to take action in order to change an unfavorable circumstance. That is to say, caregivers should advocate for their patients by actively engaging in their stories despite the continuing challenges of institutional pressures to see more patients and document the encounters encroaching on the simple act of caring for the patient.

When the patient in DKA was admitted, I was mentally preparing myself for the next admission that may come during a busy overnight shift without having fully devoted my attention to the patient that was already in front of me. I asked her if she had taken her insulin as prescribed—"no" she said. My unwarranted prejudice was that she was a teenager who did not want to inject herself and break skin or that she was rebelling, either against her parents or against herself. I discussed the next steps in her care, reciting the DKA management algorithm I had memorized, as the astute doctor I thought I was, and I finished by asking if she had any questions. She did not have any. "But . . ." she said softly. She ashamedly admitted that her prior foster family had not accurately communicated her insulin regimen to the foster family she recently joined, and she was trying to stretch her supply of insulin to last just a little longer before running out. She had a most mature insight, contemplating—with herself or with me, I am still not sure to this day—that she may have more consistent visits with her doctors if she herself had consistent caregivers. She had not allowed herself to be navigated across my algorithm without resistance. I was out at sea searching for the lighthouse to guide me back to shore. I found myself outside the safety that a checklist afforded me, and I considered myself vulnerable after having once been so well prepared. Her hospitalization was a cry for help, one that I would not have recognized had I remained in the maze that was the algorithm. She may simply find herself back in the same situation if we did not uproot the source of her problem. Because of situations similar to this, it is common practice at my residency training institution to consult social services when a patient is admitted in DKA. A thorough investigation is made to identify which social factors could prevent patients from receiving optimal health care. Doing so can prevent a potentially life-threatening event, such as cerebral edema, from occurring.

In regard to the patient with a urinary tract infection, could I blame her for not finishing the course of antibiotics after she felt better, once the burning sensation subsided?

Seeing her again was an opportunity to educate her on the importance of finishing a course of treatment. As I explained the instructions, I picked up on the family's lilting accent. However, the father's confidence did not let on that he may not have completely understood the instructions I provided, especially after jovially exclaiming "very good!" with a thumbs up. He reminded me of my own father when we immigrated from Mexico to the United States, and how I had already experienced firsthand just how communication breaks down when the language is not one's own. I asked if they spoke a language other than English—"Turkish" they said. I called an interpreter to verify our reciprocity.

Caring about our patients has an impact on health care as a whole—the "Swiss cheese" model of medical errors recognizes *active failures* on behalf of caregivers as taking many different forms, such as slips, lapses, fumbles, mistakes, and procedural violations (6). One study estimates that medical errors cost the US economy nearly \$1 Trillion in "lost human potential and contributions (7)." It should be noted that quality improvement efforts to develop system-wide standardized protocols aim to attenuate such active failures and therefore increase patient safety. Yet, Dr Terry Canale, an Orthopedic Surgeon, could not have been more precise in his adaptation of Theodore Roosevelt's statement: "Patients don't care how much you know until they know how much you care!(8)" In addition, a growing body of literature recognizes relationship-centered care as resulting in improved patient outcomes and overall public health (9,10). Furthermore, physician mental health has a direct impact on the quality of medical care (11) and attempts to address and minimize errors in health care should take into consideration physician mental well-being. After all, a caring caregiver is the product of a system that cares about its caregivers.

This is not a hounding of standardized medicine, but rather a reminder to ourselves to continue practicing the Hippocratic oath we took when we began on our journey—as many of us echo—to "help people." Our medical training provides us with the skills and knowledge to "do no harm"; we can be a passive audience and do just that, but caring about our patients allows us to actively "do good." The same patients who may make us frustrated are the same patients whom we took this oath for, and they are the same patients whom we should continue advocating steadfastly for.

We have the privilege of caring for many different patients every day. Standardization in medicine allows us to provide health care effectively and efficiently to all of them, but the end result should not be simply a provision of services as a business transaction. Algorithms provide us with a framework to practice medicine, but they may fall apart when the human equation is taken into account. Furthermore, effective SDM is rooted in physicians' collaborative partnerships with patients; physicians can gain satisfaction from such patient-physician partnerships in care, if they make such partnerships a priority in their practice. Whether being responsible for a patient with abdominal

pain, or a patient with diabetes in foster care, actively caring about patients by reflecting and engaging in their stories can result in less medical errors, and indeed more medical benefits, which is by definition higher quality care.

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Author Biography

Julio Ramirez is a parent and Pediatrician. He spends time balancing both responsibilities, and he knows that both are very rewarding and at times challenging. When he is not caring for patients, he enjoys spending time with his amazing wife and his wonderful family. He has two daughters, both of whom light up his world and always keep him on his toes. He will continue his training through fellowship in Academic Pediatrics at Baylor, Texas Children's Hospital.