"The Secret of the Care of the Patient Is in Caring for the Patient"

Holden Caplan, MD

Mr J arrives at the hospital at 11 PM with acute shortness of breath. At only 58, his health has worn him down to look 20 years older, after a heart attack at 50 left him with congestive heart failure. Without access to his medications—Lasix and Entresto—for over a month, the levy has broken, his legs bursting out the fluids his lungs laudably attempt to fend off. Knowing the urgency, he gets himself to the hospital.

In the emergency department, a resident quickly gathers history and uses point-of-care ultrasound, revealing diffuse B-lines and a heart thickened like a boxing glove. After a hefty dose of Lasix, Mr J begins to feel some relief. As the sun rises and the new shift arrives, the emergency resident calls to admit him.

Stanley, a fresh intern and aspiring cardiologist, is on the Resident Admitting Service team, which has the sole focus of admitting patients for swift throughput. He listens to the emergency medicine resident's sign-out, evaluates Mr J, finds him stable, and begins slow guideline-directed therapy while continuing diuresis. Stanley suspects poor adherence may stem from grief—Mr J lost his wife to ovarian cancer last year, and she had always handled his medications. As Stanley starts to express condolences, his phone buzzes with a barrage of new admissions. Thanking Mr J for his time, he leaves to present the case to the attending, types a focused history and physical examination on heart failure management, and moves on. There is no time to fully explore Mr J's grief or mental health in the note. The attending visits the patient, attests the note, and continues with her Sisyphean list of impending admissions. Mr J now waits on a placeholder service until a general ward team becomes available.

The admitting team finishes its shift at 5 PM and signs the patient out to the covering resident who helps reduce afternoon workload. The covering resident glances over the handoff, sees "stable" next to Mr J's name, and doesn't probe deeply into the brief sign-out, and for fair reason. In 4 hours, he will be signing the patient out to the night team resident. Brief again: "Older male. Heart failure. Stable. Didn't take his meds. Getting Lasix. Hold off on more Metoprolol unless you want to send him into shock." She continues with admissions and nursing calls throughout the night. At 5 AM, she is told Mr J can be transferred to a ward team. She opens a transfer template and composes a hospital summary paraphrasing previous notes.

At 7 AM, the day team arrives, and they learn about their new patient. Sleep deprived, the night resident mumbles, "Seems like a normal heart failure admission. Didn't hear anything from him overnight. Sorry, I don't know much. The patient was admitted by the Resident Admitting Service." The intern briefly reviews Mr J's chart and squeezes in a pre-round visit. Labs look better; the patient appears stable.

When the attending arrives, the intern gives a brief history and physical examination based on what they were able to scramble together about Mr J. The attending does not have any questions because she knows the intern does not have any answers. Separately, they begin piecing together the past 24 hours. Nevertheless, Mr J now has notes attested by 2 hospitalists in 24 hours along with a transfer note, generating more RVUs and reducing admission time from 4.5 to 1.5 hours. The hospital administration calls this a "win-win."

Mr J continues to be diuresed in the hospital daily. He remains pleasant throughout his stay, compliant with treatments, quiet and brief during interactions. On day 5, he's off oxygen and walking at baseline. "I feel fine," he says. Discharge is set. He's given a bag of medications to last the month and encouraged to follow up with cardiology. The intern signs discharge orders. The nurse reads his instructions. Mr J leaves before noon to make room for incoming patients. The flustered intern doesn't have time to say goodbye before Mr J is already out the door.

Mr J returns 3 months later after his neighbor found him lying on the couch, frail, cold, and weak. He took the medications as directed, but once they ran out, he never got new ones. Mr J has not left the house since discharge, spending his time sitting on the couch, counting the hours of the days away, eating when prompted by the neighbor. Sleep rarely comes, haunted by images of his wife's decline in

DOI: http://dx.doi.org/10.4300/JGME-D-25-00446.1

Editor's Note: The title is quoted from Francis W. Peabody, MD.[1]

their shared bed. Her illness consumes him and his health.

He's transferred to the ICU in cardiogenic shock. His heart, now too weak, cannot recover from the wear of cardiomyopathy. His only visitor is a nephew who comes to arrange hospice care after the intensivist explains the prognosis. He passes days later.

Stanley saves Mr J's name in an EHR list he uses to keep tabs on interesting cardiology cases. The tombstone grey tab at the top of his chart marking him as deceased is now too familiar. Stanley briefly reviews the ICU note to learn the intensivist's approach to acute heart failure management. No mention of the wife. Closing the tab, he pulls up the next admission: "altered mental status." Stanley sighs, picks up his stethoscope, and heads to the emergency department. Thirty minutes to meet a patient he may only ever meet again by chart review.

Reference

1. Peabody FW. The care of the patient. *JAMA*. 1927; 88(12):877-882. doi:10.1001/jama.1927.02680380001001

Holden Caplan, MD, is a Resident Physician, Department of Internal Medicine, University of Maryland Medical Center, Baltimore, Maryland, USA.

Corresponding author: Holden Caplan, MD, University of Maryland Medical Center, Baltimore, Maryland, USA, hcaplan@som.umaryland.edu