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GesmerUpdegrove<sup>LLP</sup>

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## CONSIDER THIS:

### #56 Standards of Patient Care

Andrew Updegrove



There are not a few commentators that would tell us that the latter half of the 20<sup>th</sup> century will best be remembered as the Computer Age, a time when advances in information technology truly transformed the way we live our lives. If medical science continues to advance at current rates, I believe that the first half of this century will as likely be recalled as the Age of Life Science – the time when our lives were transformed at the metabolic level. Indeed, on every

front, whether it be genomics or oncology, neurology or stem cell research, reports of dramatic discoveries arrive almost daily, many suggesting the promise of cures that only a short time ago would have seemed little short of miraculous.

With these advances has come a mighty proliferation of medical specialties, technology and tools. The hospital of today veritably swarms with health care providers, and hitherto unitary disciplines continue to speciate with an energy that would astound Charles Darwin.

*There is art as well as science to healing. And so it is that there are, human standards for health care that cannot be quantified, and should not be forgotten.*

At their beck and call are a host of room-sized diagnostic tools developed by their engineering peers, and no modern hospital can now compete for business unless it is chockablock full of CAT Scan, MRI, PET Scan and other wildly expensive machinery that peers into the body to extract information hitherto unavailable, often illuminated by exotic dyes and radioactive imaging agents.

Happy the modern citizen must be, then, to live in this age of science and specialists; how fortunate to be at the center of so much science, technology and expert attention.

Happy and fortunate indeed. That is, unless that citizen actually has to be in a hospital, beset upon by those swarms of specialists, and constantly wheeled through forbidding corridors to the nether regions of the facility to be splayed under, inserted inside, or (worse yet, as I am informed by patients of the feminine

persuasion) have sensitive parts of her body mashed between the frigid plates of an infernal medical device delivering images that too often hold prospect of only worse to come.

But at least with so much exquisitely trained attention, the quality of the care must be of the highest, and unfortunate outcomes lower than ever before. Right? *Right?*

Well. (How to say delicately?) Ah yes – here we are.

Let us consider this:

Back in the Dark Ages of Medicine (i.e., just before that Computer Age we were discussing a little while ago), only about a dozen medicines – most of ancient, herbalist origin – were of known efficacy in the ages-old battle against disease. Aspirin to treat fever, inflammation and pain (Native Americans chewed willow bark to extract the same active agent); quinine to suppress malarial attacks (the Quechua Indians of Peru used cinchona bark to quell fevers and tame chills – and invented tonic water in the process); opium from poppies to alleviate physical pain (some employed the substance to address other types of pain); digitalis from foxglove for heart arrhythmia; mercury in its elemental form as a brutal treatment for syphilis ("spend a night with Venus, and a lifetime with Mercury"). A handful of other medicines completed the pharmacopoeia of efficacious remedies throughout most of our national existence, from Colonial time until World War II. Those compounds, and a few early vaccines – most notably for hydrophobia (rabies) and smallpox.

Eventually, and thank heaven, the blessings of ether were discovered for surgery. No longer, at last, was the measure of a surgeon's skills his ability (there were no "hers" in the surgical theatres of the time) to cut a patient for the stone in less than seven minutes. Around the same time, the importance of antiseptic care was appreciated, and patients at last became more likely to survive a hospital stay than not.

But while anatomy and principles of public health became better understood, the causality of non-infectious diseases like cancer and the nature of debilitating heredity diseases remained locked in black boxes of mystery, until Watson and Crick cracked the lid. Worse, a host of implacable maladies now virtually unknown to modern society harvested their victims year by year: scarlet fever, diphtheria, pertussis (whooping cough), measles, mumps, tetanus, rheumatic fever, the dreaded summer visit of the polio virus, and more. Together, these grim and common diseases culled the children of families everywhere. Indeed, any American above the age of 80 who came from a large family would as likely as not be able to tell you of the loss of one or more or siblings to these scourges.

In these still-recent days before the advent of penicillin and sulfa drugs, decoded DNA and modern cytology, there was only so much that a doctor (like my grandfather) could do. Indeed, the principle role that a physician could play in the case of infectious or hereditary disease was to visit the sick at their homes, try to make them comfortable, and predict for their families with some degree of accuracy what would happen next. Almost as the shaman of primitive societies was brought by the family to mediate between the real and the spirit world on behalf of the

afflicted, doctors before the age of modern medicine too often could only share what they knew from observation, and like their patients, patiently wait.

The result was a special bond between patient, family and physician – with the patient and doctor at the center, both engaged in a conjoint, often powerless struggle with forces largely beyond their control. A good doctor was therefore humble, knowing the limits of his ability to influence the outcome. With so little to offer by way of efficacious care, the ability to give comfort and courage was as important as the limited ability to take curative action. And with so few investigative tools available – all of which could be carried in the legendary doctor's black bag (my father still had one for house calls when I was young) – the physician's powers of visual and tactile observation in days gone by were acute; much more so than those of today's lab-dependent doctors. As Lewis Thomas reminisced in his wonderful book, [The Youngest Science: Notes of a Medicine-Watcher](#), a physical exam performed by a skilled physician could be a beautiful, as well as an informative, thing to behold.

Today, almost all of that world is gone from the modern American medical scene. Instead of the single physician visiting the patient at home, or visiting the hospitalized patient twice a day, there is now a post-operative care team that commonly includes the surgeon, anesthesiologist, pain-control physician, plastic surgeon, oncologist, medical attending physician, multiple interns, and more. Each treats a piece of the patient for a few minutes out of the day, and each may contribute to the chart. Mistakes – thousands of them every year and many of them fatal – are made.

*Somehow, we have become possessors of (or perhaps possessed by) a vastly expensive and too-often fallible medico/pharma/insurer/industrial complex.*

Almost as regrettably, from the standpoint of effective treatment, none of the attending physicians really "knows" the complete patient, because each is a specialist, and so much has been delegated to so many other professionals to whose professional judgment each must, to some degree, defer. Such a system could conceivably work if the entire school of physicians swam together through the hospital on twice-daily rounds, but of course they do not. Instead, each must follow the breadcrumbs of the others via common review of the paper and/or electronic medical record of the patient, supplemented by occasional one-on-one consultations.

And, perhaps, a few words with the patient. But the number of doctors that sit on the end of the bed, or put a reassuring hand on the shoulder, is fewer year by year. With the proliferation of specialties, it is easy for a medical student to find one where patient skills might seem to no longer matter so much (but of course they always do, to the patient). As one physician recently said to me, "There are only two types of oncologists: saints and jerks."

The patient, it seems, is no longer truly at the center of the health care concept. Instead, it seems that role has been taken by the reimbursable "disease condition" around which vital signs, laboratory tests, scans and specialists orbit.

Somehow, we have become possessors of (or perhaps possessed by) a vastly expensive and too-often fallible medico/pharma/insurer/industrial complex. When in its custody, the patient (no matter how sick) is awakened every four hours, night and day, to have vital signs taken, and at least once a day (usually at 5:00 AM), to be pointed at and discussed upon by a resident with multiple interns in tow as part of the hospital's medical training program. When the appointed hour finally comes, the patient is delivered (by wheelchair) back to the street, often too soon for ideal care and comfort, due to the outrageous costs of so much Balkanized attention.

How did we arrive at such a pass, where the humanity and well being of the patient has receded so far beyond the horizon, to be replaced by some cold and clinical abstraction of the word "care?" And what of the future, when the doctor need not even visit the hospital room to review a chart? In the imminent future of electronic health records, will the patient find herself speaking not to a doctor at her bedside, but to an image on the television hanging high on the wall, as each specialist makes his "rounds" via video link as expeditiously as possible, sitting at his remote computer terminal, patient records displayed on a second screen?

A ridiculous suggestion? Perhaps. But things tend to happen once they can – and especially so when they become more cost-effective than the ways of the past.

If we are to pull back in time from such an Orwellian future of patient "care," we need to remember that there is still an art as well as a science to healing. The time is now, if indeed it is not already too late, to recognize that there are human standards for health care that cannot be quantified, and should not be forgotten.

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