Reflections on the care of the patient

Professor Robert Tattersall

Today's diabetes world is fast-moving and exciting; knowledge is accumulating at an astonishing rate. To help understand the present, however, it sometimes helps to examine the past.

In this installment of *Tattersall's Tales*, Robert Tattersall reflects on the need for holistic care and listening when managing people with diabetes, emphasising the importance of the personal relationship between physician and patient.

As one gets older I suppose it is normal to look back to a time 30 or 40 years ago when things seemed much better. "Better for who?" one may ask. As a house physician in 1968 I looked after people with leukaemia and lymphoma whose prognosis was hopeless, so things have certainly improved for them. In the treatment of diabetes there have also been impressive scientific advances, although it is debatable how much human insulins and insulin analogues have contributed.

What seems to me to have deteriorated considerably is what one might call holistic care of the patient. I am probably not alone in my concern that the sheer volume of people with diabetes, the pervasive influence of guidelines from on high and the influence of managers are adversely impacting on care. In short I worry that in many settings the treatment of diabetes is becoming mechanistic and unthinking. Lewis Thomas (1983) regretted that "medicine is no longer the laying on of hands, it is more like the reading of signals from machines". Faced with a busy clinic there is a danger that even the most empathic doctor will slip into autopilot and concentrate exclusively on the blood glucose and haemoglobin A_{1c} levels and never find out what is really bothering the patient. The worst example of this is a story told by a patient of mine who went to something called a "vascular risk clinic". He told me that the physician he saw (whose name he did not know because he never introduced himself) spent the whole consultation looking at my patient's results on a computer and eventually printed out a sheet instructing him what to, and (at greater length) what not, to do.

Then there is the issue of time. For "difficult" patients – usually those with brittle diabetes or general medical patients with obscure, repeatedly investigated symptoms – I used to schedule an hour-long appointment that gave time to review the notes and explore the patient's thoughts and feelings. I well remember one such patient, the wife of a consultant, who had had innumerable investigations without any diagnosis. At the end of the consultation, I said "I am afraid that, like all the other doctors you have seen, I can't put a name to your condition". I was surprised when she replied, "thank you, I feel much better". "But," said I, "I haven't done anything". "Yes, you have," she said, "you have listened". I was reminded of this when I read an article in which an American gastroenterologist was criticised by his chairman for "only" seeing three patients in 3 hours while his junior in the next room saw 12 in the same time. "Of course," he remarked, "each of my patients was referred because nobody else could solve their problem and each came with 3–4 inches of charted data" (Brandt, 2005).

When we appointed a manager for the newly established medical directorate in the 1990s, I persuaded the powers that were that the neophyte manager should shadow me for a week to find out what a physician did. This was a real eye-opener and convinced him that there was no such thing as a standard medical patient who took a standard time.

This brings me to one of my historical heros, Francis Peabody (1881–1927). Peabody was a contemporary of Joslin at Harvard and in 1906 gave his first medical presentation in which he reminded the audience that "we must not forget in treating diabetes that we are treating a man and not a disease" (Rabin and Rabin, 1984). Unlike Joslin, he did not become a superspecialist in diabetes but was a supreme generalist in academic medicine. In the summer of 1926 after a haematemesis, he was found to have an inoperable malignancy. In November of the same year he gave his classic lecture "The Care of the Patient" (Peabody, 1927). He began his talk by saying that "the most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or to put it more bluntly, they are too "scientific" and do not know how to take care of patients". Noting that one cannot become a skillful physician in 4 or 5 years at medical school, he suggested that the magic ingredient to make the expert was experience.

He emphasised the importance of the intimate personal relationship between physician and patient "for in an extraordinary large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients". As he pointed out this relationship was easier to establish with private or outpatients because those in hospital tended to become dehumanised.

For Peabody, the "clinical picture" was not a photograph of a man sick in bed but an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears, a background which he pointed out was liable to be lost sight of in hospital – or, I am tempted to add, certain sorts of diabetic clinic.

The last part of his lecture was devoted to "patients who have nothing the matter with them". He uses as an example Mrs Brown who has abdominal pain and is only interesting to her doctors up to the point where all the investigations come back negative. Peabody wrote that, "As soon as organic disease could be excluded the

whole problem was given up, but the symptoms persisted. Speaking candidly, the case was a medical failure in spite of the fact that the patient went home with the assurance that there was 'nothing the matter' with her". Failure to deal with the problem in a scientific way led, as Peabody pointed out, "to a long and miserable life and [such patients] may end up by nearly exhausting their family and friends". Their symptoms were, he thought, caused by physiological functions being upset by emotional stimuli. To show that this was possible he cited the example of students who get diarrhoea or palpitations before an important exam. "Every one," he wrote, "accepts the relationship between the common functional symptoms and nervous reactions, for convincing evidence is to be found in the fact that under ordinary circumstances the symptoms disappear just as soon as the emotional cause has passed. But what happens if the cause does not pass away? What if, instead of having to face a single three-hour examination, one has to face a life of being constantly on the rack? The emotional stimulus persists, and continues to produce the disturbances of function. As with all nervous reactions, the longer the process goes on, or the more frequently it goes on, the easier it is for it to go on."

To those who say, "I totally agree but this is a job for the psychiatrists", I would quote Alec Cooke (1994) who wrote that "all doctors in whatever branch of clinical medicine they work, cannot avoid being psychiatrists because all their patients have minds as well as bodies". Peabody made the same point when he ended his paper by saying, "Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. The good physician knows his patients through and through, and his knowledge is bough 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."

"Hear, Hear", say I.

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