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Care with care

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"The doctor, the hospital system, is the enemy." Those words jump out at the reader on the first page of a book entitled *Care Without Care*.[1] The author is Barbara Fisher Perry, the embittered mother of a child with Apert's syndrome, and the book is a blistering denunciation of the impersonal and dehumanizing nature of our medical care system, a system that from her viewpoint all too often loses sight of compassion and concern for patients and their families. Unfortunately, she is not alone in these opinions, for in the lay press one can easily find articles that portray medical care as dangerous, unnecessary, expensive, and impersonal. Is there perhaps some truth in these accusations? Have we really become high-priced technicians instead of compassionate physicians? Has the practice of medicine really come to this? For a few moments I would like for you to think with me about how we as physicians can learn from what this mother is trying to say to us and how we can render care *with* care.

I have always believed that most entering medical students set out with an idealistic view of medicine, but I also believe that this altruism gradually becomes eroded by the realities of practice and the pressures of our profession. We really are very lucky, you know, and we have many reasons for holding on to the idealistic view of medicine that most of us had when we entered medical school. We have a stimulating and rewarding job that pays well—which is surely one of life's greatest blessings. Precious few people in this world enjoy that luxury. We have a position of prestige and trust in our communities—perhaps tarnished a bit compared with the horse-and-buggy doctor, but still there to a remarkable degree. We have an opportunity to impact on people's lives at moments, which to them may be critical for years to come.

What then, gets in the way and allows cynicism and indifference to replace compassion? We might argue in our defense that reasons for becoming calloused and unfeeling include: tough years of tedious preparation and training, long nights filled with fatigue and frustration, harrassment from an ever-encroaching federal bureaucracy, the intrusion of corporate middlemen into the practice of medicine, the ever present specter of potential litigation, a more sophisticated and demanding population, stiffer practice competition and interspeciality haggling over the medical-care dollar, tighter controls and more meddlesome interference from insurance companies, a Congress bent on curbing escalating health care costs and clearly unsympathetic to the problems of the medical profession, and pressures and overbooked schedules that keep us from our families and the pursuit of pleasure. Certainly, these are all real concerns, but somehow we have to keep in mind that patients did not bring about all these problems. Our patients are *not* the enemy.

Technology gets in the way too. We sometimes be-

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come too enraptured with the technical aspects of hand surgery, and that can also depersonalize patient care. One of my favorite passages in *Operative Hand Surgery* is in the opening paragraph of the chapter on "Open Injuries" by Paul Brown,[2] where he wrote:

> Most of the severe injuries of the hand are open injuries—and how intriguing they are! The surgeon may be fascinated by their sight and challenged by the laid-open and distorted hand. So he should be, but he should proceed cautiously, lest the fascination lead to surgical myopia with such concentration on the surgical problem that the patient is neglected, leaving him under the care of a surgical technician and badly in want of a physician.*

Attending a meeting such as this reminds us of the incredible array of high-tech advances that continue to be made in the art of surgery. We possess the technical skills to repair 1 mm vessels, to replant entire limbs, to transplant skin, muscles, nerves, and toes—that work.

But do we also have the skills to reach the anguish of a patient who has lost or mutilated a hand; the sensitivity to appreciate that even a relatively minor hand deformity or disfigurement may be the source of deep psychic distress; the compassion to truly understand the emotional and psychological impact of a devastating injury that prevents a person from working, from supporting their family; the patience to explain something we do not understand ourselves to someone whose life has been disrupted by reflex sympathetic dystrophy; or the insight to comprehend that so many little things that we regard as insignificant, in fact, may be sources of great apprehension for our patients and their families?

We all spend an incredible amount of time and energy in becoming competent hand surgeons—should we not also devote some time and effort to learning how to be good physicians? Hand injuries often have a profound emotional, psychological, and economic impact on patients.[3,4] If we ignore these critical aspects of the injury, we will consistently fail to give our patients the best we have to offer. Three members of the Society from Milwaukee recently published studies[5,6] on the early psychological aspects of severe hand injuries. They reported that an astonishing 94% of their patients experienced some type of adverse emotional response, including nightmares, flashbacks, preoccupation with phantom limb sensations, cosmetic concerns, denial, and even fear of death. The spectrum of psychological reaction to injury is indeed broad. (Personal communication, M. L. Gerstenzang, 1989.) Just think about the patients in your own office. There is the patient with preexisting emotional instability who may welcome a physical problem to give credibility to his neuroses. There is the dependent person who may need support and care in excess of what is normally sufficient. There is the obsessive individual whose rigid and ritualistic life style has been dealt serious disruption. There is the high-strung, hysterical person who reacts emotionally and instinctively to stress. There is the macho man, the passive personality, the secondary gainer, the malingerer, the worker with compensationitis, and so on.

We are all aware that our patients experience psychological problems, but what do we do about it? Do we ignore the warning signs and hope they will go away? Or do we anticipate these very real emotional responses and seek ways to lead the patient through difficult times? I am not a psychiatrist, and I do not pretend to understand the subtle nuances of treating neurotic or psychotic behavior. My point is simply this: we are primary physicians who treat patients with hand injuries and deformities, and as such, we must become tuned in to the emotional needs of our patients. The best place to start is to create an environment of care and concern in our offices, and to enlist the help of everyone who works with us. How we treat our own employees and co-workers sets the mood for how we want our patients to be treated. Sometimes all a patient needs is someone who will listen. My father practiced medicine for 53 years, and at his funeral a long-time patient of his said, "You know, Dr. Green was never too busy to listen." Sometimes I'm too busy to listen, or at least I think I am.

Have you ever had patients who made you feel better everytime you saw them? Those patients who have an upbeat, optimistic outlook on life should serve as role models for us as physicians. We see how their positive attitudes affect us, and we should realize how critically important such an attitude is to our other patients. It is fun and it is easy to take care of the pleasant, intelligent, cooperative, and appreciative patient. The real challenge is the hostile, bitter, or angry patient and family. The reasons for those emotions may be valid or not—that is not the point—those are the patients who really need us. It is hard to practice good medicine. It is hard to give every patient 100% of your attention, concern, and intellectual skills. It is hard to go see that last hospital consult after a full day in the office when you would really rather go home. It is hard to get out of bed at 2:30 in the morning to see an unfunded, drunk patient in the emergency room. It is hard to find time

*From Brown P. Open injuries. In: Green DP, ed. Operative hand surgery, 2nd ed. New York: Churchill-Livingstone, 1988. By permission.

to read even a fair sampling of the current literature in our limited subspeciality of hand surgery. It is hard to maintain a calm demeanor and pleasant disposition when you are running an hour behind schedule and the waiting room is filled with restless patients. It is hard to be truly empathetic with patients when your mind is preoccupied with your own personal problems or troubles. No question—it is just not easy. Do we give our very best to every patient that we see? Probably not. I confess that sometimes I do not, even though I try. It is physically and emotionally impossible to give every patient the same care and concern that we would give our best friend's wife or husband or child. And yet that should be—it must be—the standard of care that we *strive* to give each and every patient.

In the process of preparing this address over the past several months, there has evolved what I call a "Blueprint for Compassion," which is simply a list of observations that I use to remind *myself* how to render more compassionate care to my own patients. Perhaps some might be helpful to you as well: (1) Listen to your patients and their families—don't do all the talking yourself; (2) Touch the patient—the gentle laying on of hands has a remarkably calming effect; (3) Be a teacher—take the time to help each patient understand as much about the problem as they are capable of comprehending; (4) Don't be afraid to say, "I don't know." Patients will respect your honesty; (5) Do your very best to correct those physical problems that can be improved, and help the patient learn to live with those that cannot be made better; (6) Enjoy what you are doing—live each day in itself and be thankful for the joys of our professions. Each of you could add other lines to this blueprint. Do it. It will make you a better physician.

If this has sounded more like a sermon than a presidential address, so be it. I have no apologies. The business, political, and economic issues facing medicine today are indeed important—crucially important—and we must not ignore them. The technology of hand surgery is indeed fascinating and fun and critical to the end results of what we do, and we need to develop our technical skills to as fine an edge as we are capable. But we must not forget to deal with the equally important psychological and emotional needs of our patients and their families, like Barbara Fisher Perry and her child with Apert's syndrome. I submit to you that the bottom line of the practice of medicine—and that includes hand surgery—is still one physician caring for the needs of one patient. That is what it's all about.

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