



Toward a More Human Medicine

Aaron Rothstein

In his essay “How the Poor Die,” George Orwell recounts a story from 1929, when he experienced a bout of severe pneumonia and was treated in a Paris hospital, which he simply calls the Hôpital X. The essay is a frightening, dark, but humorous tale of medical care—or the lack thereof—at the time.

A doctor, Orwell relates, typically dropped by later in the day with interns and medical students, and “there were many beds past which he walked day after day, sometimes followed by imploring cries.” But if a patient had an interesting illness or severe symptoms “with which the students wanted to familiarize themselves,” the doctor would stop and attend to the patient. The attention they paid Orwell because of his “exceptionally fine specimen of a bronchial rattle” was almost too much, with a whole group of students lining up to listen to his chest.

It was a very queer feeling—queer, I mean, because of their intense interest in learning their job, together with a seeming lack of any perception that the patients were human beings. It is strange

to relate, but sometimes as some young student stepped forward to take his turn at manipulating you he would be actually tremulous with excitement, like a boy who has at last got his hands on some expensive piece of machinery... You were primarily a specimen, a thing I did not resent but could never quite get used to.

Across from him, Orwell witnessed a patient undergoing a strange medical procedure: a match was lit inside a small glass, which was then “popped on to the man’s back or chest and the vacuum drew up a huge yellow blister...It was something called cupping, a treatment which you can read about in old medical text-books but which till then I had vaguely thought of as one of those things they do to horses.”

Orwell also describes a patient (“Numéro 57—I think that was his number”) with cirrhosis of the liver due to alcoholism. This man’s liver was so enlarged that he was often used as an exhibit for lectures. Numéro 57 died in the middle of the night, although no one knew it until the morning. “This poor old wretch

*The Finest Traditions of
My Calling: One Physician’s
Search for the Renewal of Medicine*
By Abraham M. Nussbaum
Yale ~ 2016 ~ 318 pp.
\$28.50 (cloth)

who had just flickered out like a candle-end was not even important enough to have anyone watching by his deathbed. He was merely a number, then a ‘subject’ for the students’ scalpels.” As soon as Orwell gained enough strength, he fled the hospital.

Thankfully, medical care has come a long way since Orwell’s time. In the modern American health care system, patients enjoy tremendous autonomy, are generally treated with respect, and receive the best that modern medicine has to offer. They can regularly refuse lab draws, medications, or treatments. Patient advocates guide physicians, nurses, and ancillary staff to heed patients’ wishes. Patient satisfaction also plays a role in how much doctors are paid, as the government takes satisfaction surveys into account when making Medicare reimbursements. Cupping and many other old treatment methods are mostly a thing of the past (although cupping did make a surprising public reemergence with the U.S. swim team in the 2016 Olympics). Instead, physicians strive to prescribe medications and perform procedures that are supported by the latest scientific evidence. Consequently, Orwell’s experience seems far enough in the past that we don’t have to worry to the same extent about the ethical abuses or patient mismanagement that he witnessed.

All this should be reason to celebrate. More patient autonomy means

higher demand for quality health care. More data from scientific studies and further efforts within hospitals to promote quality care means patients and physicians can make the right decisions and expect the right outcomes.

But in *The Finest Traditions of My Calling*, Dr. Abraham Nussbaum, an assistant professor of psychiatry at the University of Colorado School of Medicine, argues that these tenets of modern medicine may not always be as helpful for improving medical care as they seem. And so he proposes an addition to, if not a replacement for, these guiding principles—a change in the way doctors approach and think about the patient.

Before looking at Nussbaum’s solution, however, we should evaluate the problem of focusing on quality improvement and patient autonomy. First of all, the results of these reforms aren’t always promising. Take, for example, the goal to improve the quality of care across hospitals. Nussbaum cites Atul Gawande’s 2012 *New Yorker* essay “Big Med.” Gawande, a surgeon and writer, describes how hospitals aim to create “Cheesecake Factories for healthcare,” with a standardized and proven recipe for treating each illness. Nussbaum explains that in order to achieve this, hospitals now require resident physicians “to conduct quality-improvement projects in order to complete their training,”

and “governmental regulators and insurers assess hospitals on the basis of their performance on standardized quality-improvement measures.”

Nevertheless, after about twenty years of increased attention on quality and efforts to cut back on errors, approximately “two to five jumbo-jet-loads of patients now die each day in American hospitals from preventable errors,” Nussbaum writes. According to a 2016 analysis published in the *British Medical Journal*, medical error is the third leading cause of death in the United States (a statistic not commonly known, the authors write, because medical error isn’t listed as an official cause of death). As Mark Chassin, president of an organization that accredits and certifies hospitals, has said, “improvements have been slow and have not spread.”

Even attempts to shape financial incentives for better care have had ambiguous results. In a 2016 study, researchers looked at how a Medicare program that adjusts payments to hospitals on the basis of performance affects thirty-day mortality of heart attack, heart failure, and pneumonia, all of which are incentivized under this program. The researchers found that this pay scheme did not lead to lower mortality rates and suggested that other countries should avoid similar plans: “Nations considering similar pay-for-performance programs may want to consider alternative models to achieve improved patient outcomes.”

There are also other measures that don’t necessarily provide all the reforms that patients need. Gawande has proposed checklists as a way to reduce medical error by ensuring physicians do everything they’re supposed to do. Before an operation, for instance, a checklist will prompt the health care team with the following questions: Is the patient in front of the surgery team the right patient? Are all ancillary staff members present and ready for the procedure to begin? Is the anesthesiologist ready? But a checklist cannot prepare doctors for the patient, who is human and so doesn’t always fit into a predictable pattern.

As an example, Nussbaum tells the story of a patient he met during his psychiatry residency. Bao was a forty-three-year-old Vietnamese woman who was adopted by an American family as a child. She was terribly lonely and often came to the emergency room, saying that she had headaches, chest pain, and suicidal thoughts. At one appointment with a general practitioner, Bao requested birth control pills. The dutiful internist went through the checklist of Bao’s habits and health status. Bao did not smoke (this would put her at increased risk for blood clots), was not pregnant, and did not have liver disease (birth control pills can cause benign tumors to form in the liver). The physician explained the risks and benefits of the pills. Bao acknowledged these risks and received the

prescription. But Nussbaum, knowing that this woman struggled with anxiety and depression, and that she had described herself as a virgin, worried about this prescription and inquired about it. Bao explained that she had met a recently divorced police officer who “told me he liked Asian ladies.”

Though the internist had explored all of the biological issues, he had lost sight of the patient as a person. Bao was, in Nussbaum’s words, “preparing for her first sexual encounter” with someone who “chose her for her vulnerability and ethnicity.” Nussbaum reasoned that if the relationship went awry (which, in this particular situation, seemed likely), Bao would probably cut herself, as she had a habit of doing because she was ashamed of her body. The checklist couldn’t deliver the right decision. It could only be found through asking why Bao wanted this medication in the first place. The job of the physician must concern the person as much as the person’s various parts, and a checklist doesn’t prompt this consideration.

Nussbaum also tells the story of Tihun, a fifty-nine-year-old woman who had emigrated from Ethiopia. After a hemorrhagic stroke put Tihun in a vegetative state, her family wanted the most aggressive medical care possible and asked the neurosurgeon to place a shunt into her brain that would help to remove excess fluid and relieve pressure.

For the family, it was hope for life. But in reality, it would make no difference for Tihun. The surgeon called the hospital’s ethics consult, Nussbaum, so that he could explain this to the family. It was a sobering moment for him. Although quality-improvement experts are enormously helpful for streamlining surgical procedures, there is a “limit... to their claims to improve patient outcomes by displacing the subjective judgment of physicians with objective, evidence-based guidelines.” Yes, these guidelines could help the surgeon to explain the procedure to the family and get consent, to check off the boxes on the operating room checklist, and to place the shunt effectively. But there are no guidelines for explaining “what it means for Tihun, her family, and those who care for her to keep her in a persistent vegetative state.”

Some quality-improvement measures can even impede patient care, as when new requirements to improve documentation end up distracting physicians from the patient. To ensure that they meet certain metrics and bill appropriately for their services, doctors must document individual steps of a patient’s treatment in the electronic health record. With each new billing code, physicians must use the right language so the government or insurance company reimburses the hospital properly. This kind of note-taking can be important. But the documentation requirements continue to

add up, sucking more and more time out of a physician's day. Nussbaum laments, "most days, I spend more time documenting patient care than being with my patients."

Along with a concentration on data and quality improvement, a new hypervigilance about patient autonomy and satisfaction can also be harmful to the patients it is meant to help. According to a 2013 *Forbes* article, "Nearly two-thirds of all physicians now have annual incentive plans... Of those, 66% rely on patient satisfaction to measure physician performance; that number has increased 23% over the past two years." The pressure to satisfy patients encourages physicians to do things that are not always in the patients' best interests:

In a recent online survey of 700-plus emergency room doctors by *Emergency Physicians Monthly*, 59% admitted they increased the number of tests they performed because of patient satisfaction surveys. The South Carolina Medical Association asked its members whether they'd ever ordered a test they felt was inappropriate because of such pressures, and 55% of 131 respondents said yes. Nearly half said they'd improperly prescribed antibiotics and narcotic pain medication in direct response to patient satisfaction surveys.

Satisfying patients and practicing good medicine are not always the

same. Further data on this abounds. A 2013 study of thirty-one U.S. hospitals concluded that "Patient satisfaction was independent of hospital compliance with surgical processes of quality care and with overall hospital employee safety culture." And a 2012 study using data from a large national survey found that "higher patient satisfaction was associated with...higher overall health care and prescription drug expenditures," and even with "increased mortality."

Another one of Nussbaum's vignettes illustrates the problem with giving the patient too much autonomy. In Colorado, where medical marijuana is frequently recommended by doctors (it's not officially a "prescription"), patients carry what are known as "red cards" that give them access to weed. When Nussbaum tries to coordinate care for his psychiatric patients with physicians who recommend marijuana, Nussbaum has trouble tracking any of them down, in part because they are not in the database where health care providers normally find records of prescriptions. Eventually, he meets up with a physician, a radiologist by training, who helps patients requesting marijuana. But the radiologist's professional opinions are tenuous at best and his practices worrisome. He doesn't examine his patients; he believes that sugar can alleviate psychosis; and he claims that, in Nussbaum's words, "his patients wanted marijuana. He provided what they wanted."

As Nussbaum explains, “When we understood ill people as customers, we altered the social relationship of illness.” The idea of customer choice or service in the medical profession assumes two things: first, that we, as patients, always know better than those who have trained for years to help us, and second, that we can control our own sickness and our own ability to get better if we’re given control over which treatment we choose. Of course, neither of these assumptions is true, and by acting as though they are, physicians abandon the respect and guidance they truly owe their patients in the name of patient autonomy.

To improve medicine, Nussbaum suggests that we draw on the philosophy of Sir William Osler. Sometimes called the father of modern medicine, Osler was one of the original four physicians at Johns Hopkins Hospital and a legendary professor of medicine at the Hopkins medical school and later at Oxford. In a commencement speech Osler gave to army surgeons in 1894, he explains,

As clinical observers, we study the experiments which Nature makes upon our fellow-creatures. These experiments, however, in striking contrast to those of the laboratory, lack exactness, possessing as they do a variability at once a despair and a delight—the despair of those who look for nothing but

fixed laws in an art which is still deep in the sloughs of Empiricism; the delight of those who find in it an expression of a universal law transcending, even scorning, the petty accuracy of test-tube and balance, the law that in man “the measure of all things,” mutability, variability, mobility, are the very marrow of his being.

Osler is not saying that we ought to shun reason, data, quality, efficiency, or scientific methods. Each of these things has its place. Rather, he argues that physicians should not forget about the variability of human beings and the need to attend to the particular circumstances of every patient. In other words, physicians should avoid treating medicine like a scientifically managed assembly line. If we accept Osler’s advice and see patients like Tihun or Bao as people rather than as machines made up of parts that need fixing, then perhaps we can provide the care that they need.

But a return to Osler is not necessarily the whole solution, as Nussbaum makes sure to point out. For most of medicine’s history, patients were often treated like specimens, and even Osler, the great medical humanist, suggested that this was acceptable.

Alexis St. Martin was a young Canadian fur trader working in Northern Michigan in the 1820s. When one day he was shot in the stomach, he was treated by Dr. William Beaumont, a U.S. Army surgeon. St. Martin’s injury presented

an opportunity for Beaumont. As the stomach healed, it formed an opening, or fistula, in between the stomach and the skin, such that anyone could see right into St. Martin's stomach. Beaumont experimented on St. Martin for years, starving him and feeding him by turns intermittently to examine the exact process of digestion. Through this exploitative research, Beaumont earned a reputation as the founder of gastric physiology.

Praising Beaumont's efforts, including his recapture of St. Martin, who had run away, Osler declares in his speech to the graduating army physicians that "William Beaumont is indeed a bright example in the annals of the Army Medical Department, and there is no name on its roll more deserving to live in the memory of the profession of this country." Though the medical field benefited from Beaumont's observations, surely Osler should have acknowledged that these experiments were a gross violation of the patient's dignity. So while Osler's understanding of medicine can serve as a corrective to the way we focus too much on patient satisfaction and scientific precision, we ought to acknowledge the limits of the medical morality of his day.

Nussbaum therefore argues that we should simultaneously accept the best and reject the worst both of Osler and of modern American health care reform. Physicians treat disease, which requires data and scientific knowledge, but they also

must understand the patient and the patient's family, which requires human interest, empathy, and time with the patient. Doctors treat the malfunctioning parts *and* the person; and they must view the patient as a partner in a negotiation rather than an isolated autonomous individual whose demands must be provided for. If physicians become both scientists and humanists, perhaps then they can fully provide medical treatment that is worthy of the profession.

Though Nussbaum makes an eloquent case and offers a helpful set of suggestions for how to address modern medicine's problems, his book is not without its faults. His arguments are sometimes insufficiently realistic, as when he writes about how discouraged he is by medicine, how far the field has wandered from physicians selflessly providing their services to the poor and indigent. He observes that "on psych units, insurers and regulators advise discharge from the hospital when patients are 'stable,' a euphemism meaning that a patient can survive outside the hospital." These patients often leave for decidedly unstable home environments or no home environments at all. When facing issues like these, Nussbaum makes "a list of what a reimagined medicine would look like, a medicine where physicians and other practitioners could get to know people intimately, bear witness to the social injustices they suffer,

and accompany them to health and justice.” When Nussbaum shares this list with an administrator or regulator, he writes, the person looks at him sideways because nothing on his list is paid for by insurers. “But,” he assures us, “I know that everything on my list is possible.”

And yet, medicine is a profession that, unfortunately, deals with limited resources. Imaging tests, lab tests, sterile surgical equipment, and medications all cost money. There are certain financial realities that the profession must face. And as for physicians themselves, medical school costs hundreds of thousands of dollars; after this, few doctors have the resources to volunteer to help others while still supporting a family. Yes, physicians should have more time with patients, but every reform comes with a bill needing remuneration. Not everything is possible.

And while Nussbaum’s emphasis on getting to know personal details of every patient’s life is admirable, he often relies too much on personal anecdotes when more rigorous data are needed. For example, in criticizing the burgeoning role of administrators and policy makers in health care he writes:

Healthcare reform is often described as a single event, but in the hospital we experience it as a series of competing initiatives....A policy expert decides that a group of physicians should

embrace the patient-centered medical home and hire primary care providers....A business consultant decides that the number of orthopedists should be doubled to maximize revenue and starts replacing the primary care practitioners with orthopedists. Then a tech guru decides that electronic medical records will increase billing and reduce errors, so he or she persuades the hospital to stop hiring orthopedists or primary care practitioners and spend its money on technology consults.

This criticism sounds theoretical, as if the author is imagining what happens behind closed doors. But there is a real problem with bloated hospital bureaucracy and the balance of power within the medical system, and offering some numbers to show this would have been useful. For example, in a 2013 *Harvard Business Review* article, a health policy expert writes that “from 1990 to 2012, the number of workers in the U.S. health system grew by nearly 75%. Nearly 95% of this growth was in non-doctor workers.” And, today, “for every doctor, only 6 of the 16 non-doctor workers have clinical roles.” Why this change? And what does it say that a profession that centers on patients is growing its workforce in a manner lopsided toward non-clinical jobs? Indeed, data do have a role to play in this debate and can be helpful to Nussbaum’s argument, yet the reader is occasionally left out in the cold.

Nussbaum's book also contains a paucity of specific proposals. He identifies the problems well but, as a solution, offers only the vague bromide that we take into account the whole human being. That is true enough as far as it goes, but is it possible there is more? Though Nussbaum is right to criticize health care reformers who speak only in metrics and studies but miss the philosophical and theoretical basis for reform, he might have built a stronger case had he used more of their work for support.

Nevertheless, Nussbaum's book is vital and relevant. Because underneath the stories and the yearning for better doctor-patient relationships lies the question: What is the purpose of medicine? And the answer is not so simple. If the purpose of medicine is to give patients what they want, to adhere to guidelines, and to collect and analyze data in order to tweak the guidelines, then, as Nussbaum explains, "we ought to be replaced by robots." Robots, he

writes, "can already sort, count, and dispense medication; they may soon compound and even select the appropriate medication for some conditions. Robots can assist pathologists and radiologists through visual-recognition software....Robots can allow physicians to remotely examine patients." And with robots we easily avoid Orwell's inhumane hospital experience. So what then is the job of the physician? For Nussbaum, the answer begins with taking a step back and thinking of the sick person as a human being rather than as a machine with one broken part or another. This is the initial and perhaps most important step toward exploring that question. We should be thankful to Dr. Nussbaum for a book that demonstrates this. The rest we must fill in for ourselves.

*Aaron Rothstein, M.D., is a neurology resident at the NYU School of Medicine. His blog *Practicing Medicine* can be found at practicing-medicine.thenewatlantis.com.*