Rounds

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She was admitted to a four-bed ward that had been converted into a temporary intensive care unit. Although she suffered from scleroderma, she was there because she had experienced 22 minutes of ventricular tachycardia interspersed with bradycardia, her heart obviously suffused with the debris of connective tissue disease. Her bed stood by the entrance to the lone bathroom, an unfortunate location for anyone hoping to rest—the nurses came and went, emptying urinals and other containers of alien waste, repeatedly flushing the toilet that served as an irreverent alarm clock that prohibited repose from the constant torment of disease. A pulse oximeter hung from her earlobe because her fingers were sore and ulcerated from Raynaud's, the digital blood flow reduced to a blue-pale coloration reminiscent of fresh death. It was a noisy room contaminated with the continuous beeps and blips emanating from the various monitors as well as the chatter of the nurses as they tended to the ill. It was early morning, and I was standing by the right side of her bed, my sister-in-law seated to her left.

Then, a muffled echo of footsteps and voices, followed by the entrance, an event that has been choreographed thousands of times in teaching hospitals across the country: the erudite and mature attending physician, easily identified by his fine wrinkles and salt-and-pepper hair, surrounded by six eager and obedient young faces, all rushing through the door like newborn ducklings trailing a mother duck. This was the intensive care unit teaching team. They stopped at the foot of her bed, opened the chart, mumbled a subdued conversation among themselves, closed the chart, and—en masse—turned and left. Not once did any of the team speak to her, to me, or to my sister-in-law. But one lone soul stopped to tell us he would be back to answer any questions we had, then scurried out the door—most likely a medical student or first-year resident.

This was her contribution to, and participation in, the time-honored medical rounds, where knowledge, empathy, compassion, and respect for the patient are supposedly instilled in the embryonic minds of future physicians. I had been a part of this theater of medicine 26 years earlier, yet if my synaptic memories serve me right, my young colleagues and I spoke to the patient: we depended on listening to his or her story to refine our diagnostic skills, and, even more important, to care for a fellow human being in the throes of disease. Yes, we had radiographs and laboratory data, but the patient was the center of our attention: his or her words, thoughts, concerns, and fears were the podium of our education. Unfortunately, the rounds that I observed this day was merely a review of laboratory and radiographic images that, coupled with the wisdom of textbooks and the obligatory revelations of the most current journal article, attempted to confirm the diagnosis of the patient in bed 4. She was irrelevant; her disease was not. While she was receiving the best technical care in the world, the individual that she was seemed forgotten, her personhood tossed to the side in lieu of the intricacies of pathophysiology. I can assure you these people did not know she had two daughters who loved her very much, a sister in South Carolina who called almost daily, an elderly mother in Florida confronting the possibility that her child would die before she did, or a father who died a painful death in an intensive care unit some years earlier. They did not know her fears, or her vulnerabilities, or even the two people at her bedside that morning—nor did they attempt to.

For those who argue that my image of this event must be tarnished by a loved one's terminal illness and horrific death, I respectfully disagree. At the time this encounter occurred, I did not know she would be dead in little more than a week—perhaps I was suffering from concealed denial, but nevertheless, my mental state did allow me a modicum of objectivity. Second, it was an event that occurred more than once during her hospitalization, allowing my repeated observation, conforming in a rather abstract manner to the revered and trusted belief in randomized trials and evidence-

based medicine. Third, it was a reminiscent photograph of my own antiquated indoctrination into medical training, so I had a professional relationship that permitted an "apples-to-apples" comparison of this contemporary distillation of my past experiences.

And what do I think? First, I must acknowledge that this was the intensive care teaching team, and in the hierarchy of academic institutions, she was probably not their primary patient, so perhaps in their eyes, it was not necessary to delve into the nonphysical nature of her illness. Perhaps this is valid, but the fact remains that she was a weak, susceptible, and exposed individual in a foreign environment that magnified her fears. While I may be wrong, I have no doubt that as the medical team approached her cubicle, she was simply the 52-year-old scleroderma patient in the intensive care unit. I think that while there are many empathic and compassionate physicians (and yes, many of them cared for her during her final days of life, one in particular devoting three solid days attending to her failing body as she lay dying), I am fearful that the empathy and compassion that are reportedly imbued in modern medical training are woefully inadequate and oftentimes absent—and I don't know why. I think about this often. Has medicine become such a business that the human factor has been relegated to the trash heap? Has the paucity of autonomy or even a falling income usurped the humanistic qualities of our worthy profession? Could it be that we lack empathic and compassionate mentors to plant humanistic seeds among young, impressionable physicians? Are we simply selecting the wrong people for medical school? Or does the rigorous training that ensues during the residency years generate an emotional egress of what attracted us to this principled and honorable profession in the first place: to relieve the suffering of a fellow human being, be it physical, social, spiritual, or emotional?

Whatever the reason, we—you and I—must "right the ship," we must return medicine to its Oslerian and Hippocractic roots, roots that care for the patient in all domains. And we must remember that while we physicians are privileged members of a select vocation, we are not deities, nor are we constituents of a caste system that towers above the downtrodden of society—in fact, we are merely individuals fortunate enough to be called to the most honorable profession of all: the healing of another human being. And to that end, as someone much wiser than I once said, we must remember that it is really not as physicians that we meet the sufferer, but rather as persons that we encounter the presence of others who suffer.