



*Through a
glass darkly*

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For now we see through a glass,
darkly;

—1 Corinthians 13: 12

We live in four dimensions. In the moment, we live in three. Could we live in fewer? Suppose we had only length and width but no depth, where the depth is perspective based upon empathy for our fellow creatures? Could we live without that? Knowledge and reason give us a position, but the emotional connection with others and with the past give us a life. Without this, we risk becoming that

myth of philosophy upon which so much argumentation is based—the rational man—or, far more likely, the mechanized cog of society portrayed by Charlie Chaplin. Interactive, meaningful, human contact with life requires emotions that link us to others and without which even memories are simply a slide show. We are not speaking here of the emotional displays devoid of reason, perspective, or knowledge that are so in evidence among us today, but the interpersonal bonds that come with the understanding of another and the circumstances of that other. Are we living without these in our society? Are we doing it in medicine?

Case history

That evening I admitted a man of about fifty years in serious condition. He had a long history of smoking and a right

pneumonectomy for cancer several years before. His chart, when it came from the record room, was replete with sporadic infections and evidence of chronic bronchitis. He was garrulous, in complete denial of the situation, febrile, and short of breath. The x-ray confirmed the physical examination: all segments of the left lung were involved with pneumonia. At that time, we did our own Gram stains and laboratory work. The sputum was laden with leucocytes and Gram-positive diplococci; the white count was elevated. He was placed on oxygen, antibiotics, and intravenous fluids, given as much intensive care as we could and left to the mercies of Atropos.

After the examination and the orders for treatment, I sat with his wife. She was a quiet, fragile woman in late middle age who looked at me expectantly yet

without anticipation. We spoke of his situation, its causes, and the intensity of the treatment he was receiving. Her reply indicated that she was aware of all of this and it was why she had brought him to the hospital. She had asked him to stop smoking but could do no more. He did not listen. She looked at me as I explained the severity of his disease and the efforts we would make to reverse it. I implied that we might fail and she nodded and then picked up her purse to leave. I halted her with a word or two and rephrased my message since I thought she had not understood. She nodded again, thanked me, and left.

During the next two days I spent much time with him. He remained talkative, insofar as he could be, given his respiratory situation, and apparently cheerful about his outcome. His role in the tableau, as he appeared to understand it, was as the entertainment: serious disease for the physicians and a raconteur for everyone else.

His fever did not break and his blood pressure was kept up with fluids. As anticipated, his clinical course went slowly downhill and on the third day he became increasingly confused and died that evening.

I called his wife and she came in to the hospital. I told her again of his death and spoke with her regarding his clinical course and the mechanics of therapy as she sat quietly. There was increasing confusion on my part and some frustration as she failed to react either to my explanation or the fact of her husband's death. After some time, she interrupted me quietly, probably to stop my iterations, and said that she understood completely and thanked me for the explanation and the work to try and save her husband's life.

"But you see, I had a lobotomy and I cannot react to what you are telling me. I understand the situation, and I expected it, but I feel nothing. I have felt nothing now for many years, so you should not be concerned. Thank you very much for your work and your explanation. Now I should go and make arrangements." Then she stood

up and left the room. I sat and thought about this for some time.

Primum non nocere

The answer is "Yes!" we can live without human emotional relationships. She did and others have, but at what price? What did medicine do to her those many years ago when the leucotome went in above the eyes and cut those connections that made her human? Presumably she was difficult to manage in one way or another, so a terrible procedure, which enjoyed a vogue among some physicians for some decades and was vigorously fought by others, was employed to change her life and make the lives of her caretakers simpler. (See the excellent history of lobotomies and their influence in medicine by Mary Ellen Ford, MD,¹ and Laurence M. Weinberger, MD.²)

This woman, when I met her, was well dressed, well spoken, apparently intelligent, devoid of real facial expression,



and without emotional connection to her world. Did she enjoy seeing the sunrise; did she have children and love them; could she relate to a symphony; did she go out to see the leaves in the fall? She was a frighteningly and completely rational person. I cannot imagine how much of the flavor of life was taken from her by that procedure but I do know that she missed the essence of living. Her life must have been as grey as the clothing she wore the various times I saw her.

I did not think of her for many years but during the past few years our encounter and my reaction to it have come back with increasing frequency. Her husband and his laughing denial of his terrible situation have recurred as well. They were a team then and they remain so—Janus, caught in a situation.

The situation that caused me to think about her again, and later him, crystallized at a "Town Meeting" some time ago that our congressional representative had arranged. I admired him because he spoke directly and seemingly honestly while many representatives were unwilling to visit their constituents between elections due to their understandable fears of a verbal pummeling. In response to my question regarding Medicare administration and funding and what appetite Congress might have to reconsider the fundamentals of the program, he paused and then responded that there was no appetite and the issue probably would not be addressed until the crisis was even more acute. My reaction—and that of the audience—was, in essence, a silent shrug of the shoulders and the thoughts: "probably an honest answer" and "suspicions confirmed." Why did I and why did we acquiesce like that? No one said a word. Why were we and why was I not upset or concerned or incensed by the flagrant lack of fiscal and social responsibility by a legislative body elected to take responsibility for exactly those things? Shortly thereafter, the woman and her husband came back into my mind.

When I think about medicine and where we seem to be now, one

or the other and sometimes both of them look at me. Are we as physicians, in fact, living in a way that both that patient and his silent partner would understand? Some of us work within a greatly changed system to deliver good medical care as best we can and to game the system as best we can—turn it into a job and manage the economics—in denial of what has occurred. Others continue to give good medical care but have disconnected emotionally in order to preserve their own mental balances. Do both groups, each in its own way, avoid thinking about a noble profession that has been subverted and, perhaps, perverted by fiscal considerations?

Most of us probably act as the “servant leaders” described by Dr. Bynny in his recent editorial.³ These are people who, by example and teaching, try to make better their immediate surroundings. All physicians, particularly members of AQA, in my opinion, should be servant leaders at the very least but also should try to be more than that. There are many leaders in medicine, working quite hard to, if not change the system, at least slow its headlong plunge into simply a business. I am referring to something else here.

Quarterly earnings and market share have become important topics not only in the administration boardrooms but also at medical staff meetings. People are not being seen because of fiscal considerations and the country’s morbidity and mortality statistics place us lower among nations of the world than one would expect the wealthiest country in the world to be. We continue to maintain an enviable place in research. Younger physician-scientists are every bit as bright and dedicated as those of us who went before and the knowledge base from which they draw is far more advanced. That is not the issue. The issue is that patient care and access to that care have declined. With respect to planning for and delivery of medical care, the adage *primum non nocere* no longer applies.

A minuet of accountants

None of this is new, of course; we have known about it for years.

Physicians as a group are pragmatic and some who understood where medical practice was going joined the ranks of business in order to help manage the process—myself included. However, once involved, we were co-opted into the system and, of necessity, became part of it. All discussions have become fiscal and patient benefit and the historic and altruistic goals of medical practice have been eroded rapidly. Many of us try to help patients whenever and however we can—but when have we made a concerted, visible, and united effort to demand that patient care be given priority and that profits take a second place? It is not necessary to make fortunes in the delivery of medical care; but it is necessary to deliver that care.

The entry of big business in the 1990s, under the guise of employing good business practices to improve efficiency and cut costs was, in my view, the death of patient-centered medical care. It is one thing to change a cottage industry model into a more modern and efficient delivery system but quite another to forget, damage, and alienate the consumers in the process. Why did medicine not protest loudly on behalf of the patient? We certainly spoke about it amongst ourselves. Perhaps we were too busy trying to understand what was transpiring and to survive it. But we are in it now, and this wreckage of a delivery system will not change until the profit motive is removed.

Why not consider the delivery of medical care a fundamental social responsibility, fund it as necessary but change the business model? As one example: remove the quarterly earnings focus from large provider systems and insurers. Investors in these organizations could expect a reasonable return on investment, but as a healthy dividend—similar to a bond or utility company—rather than an incremental share price. The funds that would be otherwise paid out as earnings and administrative salaries and bonuses for fiscal performance would be returned to the system to maintain it—as is the case now—and to fund indigent care. This is but one example and there are others, but none will work until the profit motive is removed

or contained. It does not matter whether these providers are private or governmental as far as the business model is concerned.

We seem now to be a part of and sustaining members of a greatly distorted system that only Torquemada could have designed. Our excuse is that we came into it by a long series of compromises. But where is our outrage at the result and at what is taking place in patient care? Why are we as silent and rational in our acceptance as that woman? Have we, through a long process of acquiescence, subconsciously applied the leucotomy to ourselves?

We can look back through the locked glass door that allows us to see the various stages of our pasts but will not permit us to re-enter. As time and change occur, I believe we see the humanism and idealism of that era less clearly. The events of those times may be somewhat clear, but the sense and ethics of those times are dim. Is this dark glass a defense or a survival mechanism? Have we given up or do we truly not care anymore? I cannot bring myself to believe it is either of the latter. We simply need more hope and may have to supply that for ourselves by taking some action.

The editorial “AQA and Leadership” raised questions about leadership among the AQA membership and what the organization might do to assert a leadership role in medicine. Perhaps declining patient care and the subjugation of the human to the fiscal are issues on which AQA could take a position and articulate it strongly. That is, if we truly wish to “Be Worthy to Serve the Suffering.”

References

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