Southwick F. Who was caring for Mary? Ann Intern Med 1993;118:146-148.

It is hard to believe that not long ago my wife Mary was lying in the intensive care unit with less than a 10% chance of survival. How could this be? How could a young, healthy dance instructor and a mother of two children become so desperately ill? The answers to these questions tell us something about how a very healthy, seemingly invulnerable young person can suddenly become extremely ill and can help all of us to understand what can go wrong in our academic medical centers. Criticism of the very institutions that have nurtured me for more than 20 years is difficult. I now see that the lessons learned from Mary's case should be taken to heart by all who wish to return our academic medical centers to their former clinical greatness. I have waited 3 years to describe Mary's encounter with academic medicine.

Time and a move to a new university have allowed me to recount my family's experience more objectively. Despite this distance, my story remains a very emotional one. How could it be otherwise? Sometimes a profound personal experience speaks louder than averages, standard deviation, or statistical significance.

The beginning of Mary's symptoms seemed so innocent. She awoke in the middle of the night complaining of burning pains on the bottom of her right foot. Despite aspirin, the pain became sharper and more lightning-like. The next morning, her neurologic exam suggested right popliteal and posterior tibial nerve dysfunction. Could she have stretched these nerves during a straight leg kick at aerobic dance? Why had her symptoms taken so long to begin? She denied having any discomfort during her dances. Pain medications were prescribed. Mary did not get better. On the 7th day, we saw an academic neurologist who specialized in peripheral neuropathy. Nerve conduction studies revealed marked slowing in the right posterior tibial and popliteal nerves, consistent with a peripheral nerve injury. An MRI of the right leg was within normal limits. I called the neurologist to ask if he had any additional recommendations. Mary's pain was worsening. She was unable to sleep. He stated that no additional measures were indicated and added that he would be away at a research conference for the next week. He suggested I contact him when he returned. Despite several requests that he see Mary, we never heard from or saw him again. His seeming disregard disheartened both of us.

On the 9th day, blue, painless ecchymotic lesions developed under her right

fingernail and on the sole of one foot. Later that day her right ankle began to swell. A member of the primary care division ordered a venogram, which demonstrated thrombosis of the right lower venous system and of several small superficial thigh veins. The physician recommended admission but noted that she was not on call and had to pick up her children. I felt abandoned. I had specifically requested this physician because of her excellent clinical reputation, but other concerns clearly took precedence over Mary. I tried to understand. Physicians are too often criticized for not devoting enough time to their families. Mary was admitted by the on-call attending as a ward case. Admission studies showed an abnormal prothrombin time, an abnormal platelet count, and marked eosinophilia. Was she allergic to the pain medications we had initiated? Could she be allergic to penicillin? (Five days before the onset of her symptoms, she had started penicillin V potassium, which I had prescribed for her strep throat. She had taken penicillin twice before without apparent problems.) Her previous medications were all discontinued and heparin therapy was initiated.

Except for continued leg pain and a temperature of 102 degrees F, all seemed well until the fifth day of hospitalization. Mary suddenly reported that she felt "a little short of breath" and noted some sharp pleuritic right-sided chest pain. As she was examined, Mary coughed up a small quantity of blood. I thought I was going to faint. A lung scan revealed large filling defects in the right lung and small defects scattered throughout the left lung, a "high-probability scan". Thrombolytic therapy was not felt to be indicated because her heparin doses had been subtherapeutic. This was the first time I learned that her PT had only increased to 41 to 42 seconds since admission. Mary was now suffering the consequences of that inadequate therapy as she lay breathless and frightened in her bed. I rushed to the attending's office. Why had Mary not received appropriate doses of heparin? He seemed unaware of any problems with anticoagulation and pointed out that he had delegated Mary's care to the Senior Resident. He suggested that I speak to the resident. I was welcome to help with Mary's care. Being an academic physician myself, I understood the pressures that her attending was under to maintain his clinical research program while managing patients on the medicine floor. But this was my wife! I became frightened. Who was in charge? More consults were called, but no new therapeutic measures were begun. Her fever persisted and a follow-up leukocyte count was 27 000 with 49% eosinophils.

On the 8th hospital day, Mary developed a new type of chest pain. Her EKG and cardiac enzymes revealed a myocardial infarction! I could not believe it! From simple nerve injury to thrombophlebitis to massive pulmonary

embolus--and now, myocardial infarction. Nausea, fear, anger, and sorrow all flooded me with uncontrollable power. I was afraid to leave her bedside. I no longer could remain a passive observer. I reviewed her chart. There had been no mention of the subtherapeutic PT in the progress notes before her pulmonary embolus. The laboratory flow sheets had not been filled out. The chart did not contain much of the lab data generated in the last 48 hours. How could the consults or her attending know what was going on? I spent the next 2 hours filling out the flow sheets. Perhaps this act would improve Mary's care.

I again spoke to the attending physician. I pointed out that the rotating intern managing her case was overwhelmed. Clearly Mary's illness was beyond this young man's limited experience. Why hadn't he, as the attending, supervised Mary's care more closely? I tried to contain my anger. A brief look of annoyance flashed across his face, followed by a cool defense of his actions. I quickly realized that further criticism would serve no constructive purpose. Our views of proper medical management were very different. I transferred Mary to the service of a respected cardiologist whom I knew would not delegate her care to the housestaff.
That night they convinced me to leave the hospital. I couldn't sleep. I returned at 2 a.m. and found Mary sitting bolt upright in bed. She had an oxygen rebreather mask covering her face. She was gasping for air! Two hours after I left, she had developed shortness of breath. Her chest X-ray demonstrated near complete opacification of both lung fields. I burst into tears and ran from the room. I couldn't see Mary like this. The grief I felt cannot be explained. I too was hyperventilating. My head was pounding. I whimpered under my breath "Mary, Mary, my dear Mary".

If Mary died, what would I do? On my arrival home my father tried to console me. We quickly returned to the hospital. I had to remain strong. We found Mary sitting up in bed agitated, confused, and markedly tachypneic. Any movement caused her oxygen saturation to drop below 80%. She told me that she was tired and couldn't last much longer. Just before intubation I showed Mary a picture of our two children and told her to keep fighting. We all loved and needed her so much, she just couldn't leave us. She nodded. We looked into each other's eyes as the anesthesiologist gave her an intravenous sedative and intubated her. I realized this might be our last communication. Despite assisted ventilation, Mary's arterial Po2 remained at 45 to 50 mm Hg. She also became hypotensive, requiring vasopressor support with dopamine, levophed, and neosynephrine. Antibiotics and steroids were begun.

As I sat in the CCU waiting room with my brother and Mary's mother, I

expected someone to come in at any minute to tell me Mary was dead. I felt like I was sitting in the execution room and that at any minute the hangman would arrive. As I waited, I began thinking of all the wonderful things Mary had done for me and how happy we had been. I thanked Mary's mother for raising such a wonderful person. I realized I should be thankful for the 10 precious years we had had together. Why did God want to take Mary from us? I had no answer. I realized I had to begin to plan for my children's welfare. Would I be able to continue my very demanding academic career? How would I explain Mary's death to my children? The nurse came to the waiting room. I gritted my teeth. She reported that there had been no change in Mary's clinical status.

A critical care specialist arrived that evening. He had just returned from an academic conference. Rather than first going home to see his family, he came directly from the airport to the hospital to assist in Mary's care. The cardiologist, the intensive care specialist, the infectious disease consultant, and the renal consultant all remained at her bedside throughout the night. They discussed together possible management alternatives and carefully planned her treatment. I could see there would be no delegation of care to housestaff that night.

She had failed to respond to diuretics; urine output was less than 5 mL per hour. Arteriovenous hemofiltration was undertaken at 2 a.m. in the hopes of removing fluid. As the renal specialist manipulated the catheter, Mary suffered an asystolic arrest. As the alarms sounded, housestaff from every hospital floor rushed to her bedside. I bowed my head in prayer as they pumped on her chest. I thought as hard as I could, "Please Mary, don't leave me. We need you so much. Don't give up". She didn't. Her heart responded to atropine and isoproterenol. An hour after her cardiac arrest, her urine output suddenly increased; she diuresed nearly 11 litres in less than 24 hours, and her pulmonary function rapidly improved. I knew she would survive. Within 5 days, she was extubated. God, with the help of the physicians in the intensive care unit, had performed a miracle. After a year of convalescence, Mary fully recovered. We have returned to a normal life. Our experience reveals both the best and worst about academic medical centers. The ability of acute-care, full-time academic physicians to reverse what should have been the fatal complications of her illness, the adult respiratory distress syndrome and profound shock, was truly astounding. However, the care given in the earlier stages of Mary's illness can only be characterized as fragmented and at times impersonal. I was a fellow faculty member.

I can only speculate on the treatment an outsider might have received under

the same circumstances. At the onset, I had searched my medical center for an Oslerian physician, someone who could make sense of the complex findings associated with Mary's illness. I found no such physician; instead, I encountered distracted specialists whose actions implied that patient care was of secondary mportance. Mary's inpatient attending focused on individual complaints but failed to develop any unifying diagnosis. He ignored small but very important details. This experienced physician admitted to delegating Mary's care to the housestaff. The consequences of that decision reinforce the importance of close supervision. Certainly freedom to help manage patients is necessary for the growth and learning of doctors in training.

Should the physician of record abdicate his responsibilities to achieve this goal? Is it no longer necessary for the attending of record to review his patient's laboratory findings and to actively participate in the care of the patient? Those of us who are academic physicians sometimes forget the sacred trust patients and families put in our hands. We often are more concerned about finishing our papers, preparing for scientific meetings, and completing experiments. Patient care too often becomes an unwanted obligation that is seen as an impediment to advancement. When we are caring for patients, our competitors, particularly those with PhDs, are continuing to advance their research. The competition is intense to maintain funding. Deans are continually re-evaluating our ability to generate research funds for the institution. Rarely are we evaluated on our desire or ability to care for patients.

Many of the older academic physicians bemoan the lack of attention the chairpersons of medicine and the medical school deans pay to good patient care. The skilled general internal medicine diagnostician is an endangered species in academia. Outlying community hospitals now house many of our best clinicians. In many instances, these hospitals may provide better care than their home institutions. When asked directly, department of medicine chairpersons and medical school deans all agree that patient care is important. Actions, however, speak louder than words. Mary's first inpatient attending recently received a prestigious academic promotion. The cardiologist who was instrumental in saving Mary's life has left the university hospital to join a private practice at an affiliated hospital. Patient care is not being rewarded because this activity does not generate research money and does not show up as articles on the curriculum vitae. The physicians who initially cared for Mary have for the most part forgotten her illness. They were not the ones who had to pay for the oversights in her care. If Mary had died, they would have been able to continue normal lives. My life and my children's lives, on the other hand, would have been

irrevocably changed. Being an academic physician with a heavy research commitment,

I often worry about my own clinical capabilities. Would I overlook important details under the same circumstances? Given today's academic climate, no one would ever know the difference. We in the academic community, particularly the deans and chairpersons who establish the values and set the goals for our institutions, should remember Mary's illness. My personal experiences have shown me that the top priority for all academic medical centers must be uncompromising and outstanding patient care.