PERSPECTIVE

LESS IS MORE

To Cure Sometimes, to Relieve Often, to Comfort Always

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"New admission for NSTEMI. Please call the ER." My eyebrows furrowed as I looked at my pager. It was shaping up to be a busy call day. I glanced through my new patient's medical record and called the emergency department physician. It seemed straightforward: a 77-year-old man with a history of coronary artery disease was presenting with nausea, chest discomfort, and a new troponin elevation of 12.0 ng/mL. A familiar protocol of serial laboratory tests, ECGs, and medications—drilled in to me by my years of training—was the next step in his care. I still remember how I framed this gentleman as a "bread and butter ACS case" (acute coronary syndrome) to my intern as we went to evaluate him.

The patient looked a decade older than his age. His gaunt face remained expressionless as his wife and daughter told his story. This was his second heart attack in a month. Between his angina and debilitating hip pain, he rarely got out of a chair. Unfortunately, his chest pain was becoming more frequent. His last angiogram revealed no treatable targets, and his cardiologist had determined that medical management was his only option. When he was admitted, he would remain in the hospital for 2 or 3 days receiving a heparin drip and undergoing frequent laboratory tests and ECGs. His physicians would adjust his latest regimen of medications, hoping to stave off the pain that kept bringing him back. Despite maximal medical therapy, the frequency of his chest pain and monthly admissions continued. The failure of this plan went unspoken.

There was more to his story than just his heart. Two years earlier, he had started to forget the names of his close friends. He would ask his wife the same question multiple times in a day. Recently, he had become more dependent on his wife and daughter to perform daily tasks. At night, he was agitated and confused. These episodes worsened whenever he came to the hospital. For this reason, his family avoided taking him to the emergency department unless his pain was unbearable. His daughter confided, "I feel guilty when I don't act, but why bring him here if he only gets worse?"

We sat in silence as her question lingered between us. Eight years ago, I had decided to become a physician because I wanted to cure the sick, or at the very least, ameliorate their disease. Would a failure to act be a violation of those aspirations? The ACS protocol that had been engrained by my residency training seemed to be the only solution I could offer. Yet, carrying out this algorithm would likely continue a futile cycle of readmissions. How could I justify such a fruitless course to his family, especially since they felt he was suffering every time he came to the hospital? The answer was right in front of me: just ask him what he wants.

He did not hesitate to answer, as if he had been waiting all this time for someone to finally ask. "Doc, I want to be at home. I don't want to keep coming here." After a few moments of silence, he wryly smiled as he added "Having no pain would be nice too." His family nodded. In that moment, a sense of relief overcame the room. We arranged for home hospice, and he was back home the next day.

Fast-forward 6 months; something incredible had happened: not a single hospitalization had occurred. He was still taking an armamentarium of antianginal agents, but there had been a clear shift in the focus of his care. While he was on hospice, he continued to visit his primary care physician and a number of specialists. Previously, these visits had been consumed by his cardiac disease. Now, that time was free to focus on the other aspects of his life. He received a scooter to regain his mobility and independence. He received new hearing aids, was referred to a dentist and finally got around to seeing an optometrist. His clinicians now felt free to prescribe him hydrocodone for his refractory chest pain, which worked tremendously well. Maybe these things would have happened eventually, but they happened sooner because his primary care physician's focus became patient centered rather than disease centered. In fact, he did so well that he was discharged from hospice 6 months later. This is not as surprising as it sounds—up to a third of patients placed on hospice outlive their initial prognosis.[1] He continues to see his cardiologist and primary care physician on an intermittent basis, but the emphasis remains on his comfort rather than the prolongation of his life.

Looking back on his case, I am surprised that palliative care is not offered to more of our patients with refractory angina. Many coronary deaths are sudden, but other patients will suffer a prolonged series of recurrent admissions with few options for definitive care. Did an algorithm, rather than patient-centeredness, drive these protracted cases?

Protocols for management of specific conditions have transformed patient safety and quality, but physicians have little guidance on when to pause and reevaluate the goals of care. Some institutions have responded to this challenge with automatic triggers for palliative care consultations.[2,3] While goals of care conversations remain an art,[4] leveraging such tools can increase the likelihood these critical discussions will occur. Regardless of the mechanism, the freedom to step back from methodical algorithms to take a broader patient-centered view remains key. The complexity of human disease cannot be captured by an order set, and a failure to teach such flexibility may leave future physicians with difficulty in deciding when to deviate from these standardized regimens. As physicians, it is our obligation to embrace our evolving field while remaining true to a tenet that has guided our predecessors: to cure sometimes, to relieve often, to comfort always. By doing so, we ensure that the sacred tradition of medicine remains an art, rather than an algorithm.

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