Caring for the Patient: Necessary, But Not Sufficient

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While lecturing to students at Harvard in the fall of 1925, Frances Peabody noted, " . . . the secret of the care of the patient is in caring for the patient."[1] Generations of medical students have received this wisdom. Listen carefully. Make eye contact. There is a person sitting there, not a disease. Respect and empathy were and are central to both the diagnosis and treatment of many conditions. Failure to care often results in ineffectiveness of care.

Many of us learned caring by observing our teachers care. Bedside modeling, more so than didactic presentations, seemed a far more effective method to impart this core attribute of our profession. But what was modeled was more than kindness and courtesy. The caring was accompanied by discerning observations, steady hands, and a disciplined mind. A physician with a warm heart and a weak mind was and is a charlatan. Caring must be accompanied by competence. Indeed for many, the distinction between caring and competence was not made. How can one care, yet allow one's knowledge or methods to become outdated? Although caring and competence may be measured and modified differently, they must coexist.

At some point, however, the components of competence changed. This is not new. The components of competence have always changed. Yet, instead of learning a new class of medications or a new physiological system (e.g., learning about the renin-angiotensin-aldosterone

system), one had to learn about *systems*. No longer was it health care, it was health care *systems*. Boxes with arrows that point to other boxes with arrows that point to other boxes, as if lost in a James Joyce novel. Processes and outcomes. Plan. Do. Study. Act. Even the American Council for Graduate Medical Education in 2001 mandated that we evaluate our resident-trainees in "systems-based learning" (the sixth of six core competencies). Whereas my own teachers could model caring and competence, how am I to model "systems-based learning"?

In this issue of *Clinical Diabetes* (p. 149), Georgia endocrinologist Steven Leichter, former Speaker of the U.S. House of Representatives Newt Gingrich, and their colleagues provide a model of care that extends beyond the physician-patient relationship, yet fundamentally serves that crucial relationship. They highlight the importance of an informed, activated patient; an incentive system to promote specific behaviors; an electronic information platform to support decision making and prescription writing; and a program to promote physical activity. This model of improving diabetes care is presented as part of a citywide effort in Columbus, Ga., that involves collaboration with a variety of key stakeholders.

Understanding both the context of care and the determinants of outcomes beyond the physician-patient encounter is central to systems-based learning and practice. Leichter, Gingrich, and their colleagues provide a description of both the context of care and a strategy for leveraging the resources of their local system. The principles described do not require a large venue, such as the city of Columbus, to be implemented. Increasingly, physicians in both small and large settings will care well by more fully appropriating the resources (from electronic medical records to community services) available in their own settings. We've always done this. The context in which we practice has just changed.

Change is inevitable. Progress is not. It's important that we monitor many of these system changes and, like new pharmaceutical products, be prepared to keep the good and discard the bad. Most efforts will not be so black-and-white and will require more careful consideration. For example, although I have no doubt that financial incentives change many behaviors, I am concerned about physicians' level of interest in continuing to care for the sick in a system that rewards having healthier patients. Undoubtedly, incentive systems will undergo many iterations.

Sometimes, in the midst of reminders from my electronic medical record or a quality improvement planning session with my staff, I remember that the secret of providing care to the patient is in caring for the patient. Although caring may not be sufficient, it is necessary. I gotta go now—I hate to keep patients waiting.

REFERENCE

[1]Peabody FW: The care of the patient. *JAMA* 88:877–882, 1927