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A Case for Patient Ownership

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"In order to be a good resident and a good physician, you must take ownership of your patients."

The words rolled off his tongue quickly, like a reflex. He was an Internal Medicine senior resident, approaching graduation, seated at the front of an auditorium, providing advice to the intern class as they approached their senior residency. He heard the idea of ownership incessantly throughout his own time in medical school and residency. Ownership was supposedly the key to being a good physician.

He looked around the room and saw stares from so many terrified young physicians about to take on positions of significant responsibility. To him, ownership means responsibility: "This patient is mine." Their care, safety, dignity, knowledge and understanding, these are all my responsibility and are things I will provide. Ownership means treating a patient like your own family.

He recalled a night he had covered the Medical ICU as a senior resident. It was 2 a.m. and a 74-year-old male patient, not fit for surgery, was dying from septic shock from cholecystitis. He was

scared to page the interventional radiologist at that time of night. He thought to himself, "If this were my father, I would not hesitate to call." And so he called. The interventional radiologist and his support staff came in, placed a percutaneous drain, and the patient survived.

Although patient ownership is an excellent abstract idea, in practice it raises many questions. For example, how much of the patient's course do you own? Do you own the poor outcome from the ERCP that ultimately led to a perforated viscus and patient death, because you placed the GI consult? Do you own the "near miss" when you ordered an antibiotic that the patient was cross allergic to, but the pharmacist caught it in time? Do you own the accidental canalization of a 92-year-old male's femoral artery when attempting to place a femoral venous catheter during CPR as the patient's body is rhythmically shifted back and forth as the entire code team attempts to acquiesce to the family's wishes to "do everything"?

When does ownership end? Does ownership lapse at shift change? At the end of the month when the rotation switches? At the end of residency? When the patient is discharged? When the patient dies? Does it ever end?

He recalled a troubling case he had been involved in as a second year resident. Mr. H, a gentleman in his 50s, had come to the hospital with weeks of fevers, chills, night sweats, and weight loss. Mr. H had also experienced some weakness in his legs, cranial nerve deficits and a painful disseminated rash, with ulcerative erythema and

patchy alopecia. He had taken ownership of Mr. H from the first time he met him in the emergency room. At that time, the patient was already significantly debilitated. He was unable to walk, unable to coordinate either his voluntary or reflexive swallowing, and would often choke and cough on his own saliva; but his abdominal muscles were weak and his cough often sounded like nothing more than pathetic gurgling. Mr. H was a man frustrated and suffering in a body over which he was losing control.

He spent a long time in the emergency room getting information from Mr. H. He had recalled so many times being taught that more than half of diagnoses can be made by a good history and physical exam. He learned that Mr. H was a devout Christian pastor who dedicated his life to God, teaching others, and helping all those he met. He was well travelled. He had seen many beautiful places in his life, met many interesting people. He had come to California to continue his work and spend time with friends and try to get answers about his disease. As time had passed, however, this plague had progressed. It had stolen his independence and trapped him in the decaying vessel that was once a body capable of education and inspiration. It was now only capable of causing Mr. H pain and causing frustration for Mr. H's physicians.

Every day he would speak with Mr. H, evaluate his progress, review lab tests, call in consults, and discuss the case with peers and attendings. He called in consults from nine services, ordered hundreds of lab tests, dozens of imaging studies, and

orchestrated multiple surgical procedures. Perhaps this was excessive, but wouldn't you do everything you could for your brother?

He watched Mr. H's body continue to deteriorate, becoming weaker and less responsive to its owner. Despite lack of a clear diagnosis or treatment plan, he was touched by Mr. H's continued faith in God. He paid attention to Mr. H's personal feelings and attempted to make him as comfortable as possible. He contacted the patient's friends, family, and minister so they could all be with him. He tried to nourish Mr. H's spirit, since he couldn't seem to help with his physical affliction. With a bitter taste in his mouth, he signed Mr. H's case out to the oncoming resident.

And then things got worse. A few days later, he learned that Mr. H had perforated his abdomen from a complication of his feeding tube, was transferred to ICU, was intubated, and ultimately died. Mr. H had died, but he continued to own the hospital course, the outcome, the lack of answers. It weighed him down and filled him with self-doubt.

Mr H's case was used at a conference, presented by another resident who had not even cared for the patient, as a tool to discuss how physicians deal with not knowing. His exclusion from participating in the conference left a sting deep in his chest. Mr. H was his patient; how could he be left out of the presentation? Despite the anxiety and frustration gripping his throat and almost choking him, he still attended the presentation. He listened to the case articulated in agonizing detail, each moment a reminder of his failure. At the end of the

conference he stood up and tried to take back some portion of ownership of the case. "I was the resident taking care of this patient while he was in the hospital. Even though we were not able to provide the patient with a diagnosis and our supportive care was not able to stop his ultimate demise, we were able to address his desire to be in touch with his friends and family, as well as with a minister who could address his spiritual needs." This explanation felt hollow, and he felt that what he had provided Mr. H was still inadequate.

Several months later, he was reviewing Mr. H's case. He was surprised to find a pathology report from a muscle biopsy. Mass spectrometry identified protein deposits within the muscle tissue consistent with a rare, familial form of amyloidosis seen in people of Finnish heritage. However, Mr. H was of African and Caribbean heritage. This was a novel finding, and he became part of a project sequencing Mr. H's DNA to uncover the underlying mechanism causing this disease. Now, almost a year after Mr. H had died, he was still working to find a diagnosis. He felt the weight of the case become a little lighter at the thought of finally having an answer, but almost as if the lack of diagnosis had its own inertia, he still doubted he would ever conclusively find a result. Either way, though, it would not help Mr. H.

He realized something then about the idea of ownership, and what it means for a physician. He realized the truth is that once he took ownership of a patient, that ownership never ended. Mr. H would always be his patient. The lessons from that

case became a part of who he was as a doctor. All of the patients he had cared for, the decisions he made, the mistakes, the time invested, they were all now a part of him. He had feared that this ownership might slowly overtake him and destroy him. But instead it became his base that held the weight of his responsibility, giving him strength and compassion. It was the support system that kept him from snapping like a twig under the tremendous pressure of caring for others the way a physician must. Each patient and family member he interacted with became added to the foundation of who he was. In some cases, the foundation was strengthened by this addition, in other cases it was weakened. Either way, it was an inevitable, ongoing process that would continue on for the rest of his life as long as he continued to take ownership and responsibility for those he took care of. He continued to hope that by taking ownership in this way, he might ultimately become a good physician.

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