Cruelty

It was late at the premier teaching hospital in the country, and we were overworked and overwhelmed. Those patients in most trouble had made it in, but many waited outside, a domino line from the threshold of the emergency room to the edge of the hospital. Those inside were on gurneys in the treatment areas. They were in the hallway, on chairs, or on the floor. It was the era of hyperinflation and terror in Lima, Perú. I was one year away from graduating from medical school.

A corpulent and inebriated man came in with a large scalp laceration. One of my colleagues began to clean the wound. She misjudged that he would not need local anesthesia. He responded abruptly and violently, taking a bottle with some colored antiseptic solution and hurling it at her head, missing narrowly. Her scream and the red vitreous splash everywhere acted as the Bat-signal. Other doctors in training came rushing to her treatment bay. They first tried to restrain him. Soon, the gang in white coats was holding him down and beating him up. When it was over, the man had the original laceration and the swollen, bruised, and cut face the class of 1995 gave him.
What that patient received in punches, we delivered verbally to anyone who complained and whom we chose not to ignore. This was our emergency room, and these people, the patients, were here to bother us, to interrupt us, to make our day more difficult. We dehumanized the “laceration,” the “foreign body,” or the “appendix” without seeing the destitute and illiterate patients behind those labels. These subhumans were not only unfortunate and fortuneless but, in our eyes, were also careless, irresponsible, and stupid. Like a potent drug, equal parts efficacy and bitter pill, our emergency room could save a life while demeaning it.

Decades of psychological and sociological research explain the behavior of this white-coated mob. But what about the hospital rounds led by senior clinicians? A student six years my senior wrote a graduation thesis in which he noted that these rounds, when at the patient’s bedside, almost never acknowledged the patient’s existence: no greeting, small talk, explanations, nor elicitation of worries. Perhaps a question, but its purpose was to solve the diagnostic puzzle. Perhaps an exam, but it was to detect a sign. The patient as object, the subject barely noticed.

Yet, no one told us we, the trainees, were lacking in care. We ran a complex system of redistribution by which we asked more affluent patients to bring extra supplies that we would store and use to help poorer ones. We would use one patient’s social assistance card to get free supplies for another who narrowly failed to meet the program’s requirements. Thanks to this work, patients received tests, treatments, and operations; they got better and went home; and we received recognition. Perhaps we cared, but frankly, most of our work was completed to impress our senior residents and attending physicians with our resourcefulness and efficiency.

Occasionally, this churning would be interrupted. Mostly at night, when the hospital was quiet and slow. A sudden frameshift. An
abrupt double take. The clinician suddenly noticing the person in the patient. A chair pulled. A chat.

Lines thrown from one boat to another. Permission to board.

“Who came to visit you today? Who is in that picture at your bedside?”

For an instant, the boats approached, abutted, and their wakes kissed.

Soon, they must diverge, drift, and sail away.

The clinician stands up as a new admission, a “pneumonia,” rolls in.

Elsewhere in the Peruvian hospital, the lab receptionist was sipping his coffee, mixed with the exact amount of milk. Earlier he had filled a bucket with the tubes he discarded because they did not contain the exact amount of a patient’s blood required for a test.

“No, no! The patient was a tough stick!” a trainee cried.

The lab receptionist remained unperturbed. The sample was lost, the test not run, and the intern looked bad on rounds. Sometimes the samples of several patients were lost or discarded because they came in seconds after the deadline. The man sipped his coffee, satisfied that his exacting work elevated the quality of the laboratory. The intern back at the bedside explained, “I am sorry. I have to draw your blood again.” The cruelty of the protocol, rigidly applied.

On the other side of the world, 18 years later, I met the foremost American diabetes expert. He prescribes the latest medicines. He must do so, he says, because when he goes to meetings or colleagues consult him, he is expected to have experience with the latest advances and technologies. Thus, his patients are among the first to receive just-approved drugs. Pharmaceutical representatives know
this, so they hand him glossy brochures about new medications. He is also often invited to speak at conferences about the experience he has accrued with these drugs.

Once, he and I coincided at a diabetes conference in India. One could easily see the addictive allure of his position. He was treated to luxurious events with guests from the Bollywood scene. At the end of his competent presentation, the host asked the audience to “stand up for a standing ovation.” He left in a black stretch limo. In his talk, he had recommended that local clinicians use treatments with a cost and burden difficult to justify based on existing research. These clinicians, believing his pitch or, perhaps, hoping for his status, will switch their patients, like those of the American guru but much poorer, to the latest drugs. The cruelty of fame.

Back at home, it was time for my patient to refill a prescription. For the pharmacy to refill that prescription, however, the request must be made within 10 days of the previous fill running out. But the patient remembered to call too early, 11 days before the refill was needed. The system fails the stress test of kindness. “I cannot save your request and process it tomorrow ... you need to call again tomorrow.” She forgot. A few weeks later, the patient explained to me why she did not take all the medicines. “My condition seems out of control now,” she said. Everyone was just doing their job. The cruelty of our routines. The cruelty of petty rules.

In the news, I learn of a hospital’s accounting department that has partnered with an agency to collect outstanding bills in full. The agency prioritizes the accounts by amount and likelihood of a successful collection. Agents knock door after door, threatening and harassing destitute families, some still mourning the permanent disability or death of their loved one. Some of these families had already worked with hospital representatives on a formula to pay their outstanding bills. “Our records do not reflect that,” the collectors say,
“and we will go to the end to get our money back.” The cruelty of cold cash.

In other news, a CEO announced to his board that the generic drug they just acquired will have a price adjustment of several thousand percent. Their monopoly on this “market” firmly in hand, he is moving to cash in on behalf of the stockholders. In 2016, this scene replayed in the stories of daraprim, epinephrine auto-applicators, digoxin, naloxone, and other generics. Blame was allocated to the Food and Drug Administration, or FDA, (for enforcing regulation that slows the approval of generics), to lawmakers (for not regulating pharma’s profits), to company boards (for placing beneficence far behind profits), to payers (for not negotiating drug prices, including Medicare, the U.S. public payer forbidden by law to negotiate them), and to CEOs (for doing anything for their performance bonuses). The consequences were allocated to patients, pricing people out of the treatments they needed and increasing the cost of healthcare for everyone else through hikes in insurance premiums. The cruelty of greed.

Cruelty seems to require that we, as clinicians, dehumanize patients, consider them not like us, not our kin. That we treat their suffering and dependent selves as a subspecies, as an extreme form of “them” with nothing in common with our humanity. Nothing in their name, their appearance, or their circumstance is able to bridge their distance from us. They are beds, diagnoses, samples, case numbers, or statistics. The expression in their eyes, the warmth of their heart despite their impossible circumstances, and the picture she keeps by her bedside of her granddaughter in a far-away city are all desperate gestures reaching for the reset button to make one human notice another.

Cruelty requires policies and procedures that discourage people, even the kindest, from noticing. One set of such policies defines jobs
very narrowly. I get paid to do this, not to worry about the design limitations of a system in which I am no more than a replaceable part, a part that will be replaced if I don’t do what I am expected to do. I am just following orders. Policies that retain professionals who become uninterested in the concrete downstream consequences of their actions on individual people, and thus behave unprofessionally.

Cruel policies affect how the work is done. Impossibly busy appointment schedules and heavy patient loads force clinicians, even the kindest, to see patients as a blur, noticing nothing particular about any of them. Policies that place vast distance between the administration and the hospital ward, between the receptionist and the bedside, between the decision-maker and the petitioner. This is a distance from which Ana, Jose, and Susan cannot be distinguished from each other or from other patients, all of them solidly “them.”

These policies, motivated by the same industrial justifications, often dehumanize not only the patients but also those who are supposed to serve them and help them heal, even the kindest. The dehumanization of clinicians makes them expendable and interchangeable, like lightbulbs. Lightbulbs that, as the cruel system is finding out, can also burn out. And burned out clinicians and staff manifest a key deficit: the inability to respond to the suffering of a fellow human with empathy. Cruelty incites cruelty.

And yet, amidst incidents of cruelty, we find accidents of care. A nurse stayed after her shift to help her elderly hospital patient use his laptop to witness via live video his granddaughter’s graduation. On her way home, a pharmacist took the box of medicines for a sick child traveling in Germany to the main office of the courier company after the prescription missed the last courier pickup truck. Five days after operating on his hip, the surgeon brought a chair he had at home to the patient’s hotel room to make it easier for him to take a shower. Humans recognizing each other as fellow humans,
disappointing what others expect of them, overcoming fear and violating the care protocols to make room for care, eschewing reputation in favor of a moment of intimacy that no one had to notice.

The antidote to cruelty is in the humanity of clinicians who, in a moment, remember why they went into health care. It is in rejecting the tendency of industrial healthcare to cause cruelty and to make each one of us capable of realizing our infinite potential to be cruel to others. It is in policies that make noticing each other the easiest thing to do. It is in creating space and opportunity for us to realize our equally infinite human potential to care for and about each other.

The “pneumonia” that rolled in? That is Ms. Seminario. The picture used as wallpaper on her smartphone? That is of her oldest daughter, Carmen. Ms. Seminario is afraid, short of breath, alone. She dreams of getting better so she can resume her life and embark on an often-postponed new quest. She is getting better for her children.

The clinician leans forward, unhurried.

Lines thrown, closer.

His eyes instantaneously sign a one-clause contract: “We are here now, for you and your care only.”

He questions and gets answers. They make answers.

Boats moored together. Permission to board.

Unhurried touch. Examined. Reassured.

With cruelty always a possibility, for a moment, care happens.