How A Famous 90-Year-Old Doctor Survived Hospitalization, But You Probably Won't

written by Jesse Lemisch | January 22, 2014

Enclosed in and insulated by their own structures of thought, many doctors are quite blind to the role of privilege, including their own, in getting or not getting medical care and in determining the quality of that care. If they acknowledge some flaw (or even ignorance or barbarity) in individual health care, they see it as non-systemic, simply a matter of a bad apple in an otherwise benign barrel. They may maintain this obtuseness even when they themselves become patients. Here is a stunning example: an account by Dr. Arnold Relman of his own recent hospitalization: "On Breaking One's Neck," *New York Review of Books,* February 6, 2014. Dr. Relman is a professor emeritus at Harvard Medical School, and did admirable work as Editor-in-Chief of a leading American journal, *The New England Journal of Medicine (NEJM),* which I have read for many years in an attempt to keep up with developments in medicine as well as for important material on the state of the medical profession and of health care in the United States. The episode described by Relman in *NYRB* involves another equally important and admirable figure, Dr. Marcia Angell, who is also a former Editor-in-Chief of NEJM. Angell teaches at Harvard Medical School, and is a critical writer in various areas, including medical ethics, conflicts of interest, and the conduct of the pharmaceutical companies. Dr. Angell is Relman's wife, and she "stayed long hours" with him during most of his hospitalization.

Relman writes of his survival and what he describes as his "astonishing recovery" after a life-threatening June 27, 2013 neck injury, which produced, among other things, massive hemorrhaging, on top of pre-existing atrial fibrillation, aortic stenosis and polymyalgia rheumatica, a severe disorder affecting muscles and joints. In Relman's description, he received excellent care at Massachusetts General Hospital (MGH) in Boston. Accompanied by his son (who is either a doctor or a lawyer), he went to the emergency room, identified himself, and "within a few minutes, it seemed, my cubicle filled with physicians, nurses, and other members of the staff." Relman makes no other comment on this sudden gathering of a small crowd, nor of the crowding of prominent visitors during his subsequent stay in the intensive care unit. He seems uncomprehending of the significance of the fact that the person in the cubicle was the former editor of one of America's oldest and most prominent medical journal (nor of the possibility that he had taught some of the doctors who staff MGH). Of the "initial measures" that were taken at MGH, Relman concludes that they "undoubtedly saved my life." Relman is also silent about the significance of the presence of the equally prominent Marcia Angell (who rushed back from out of town to join him). Just imagine the rapidity with which word must have circulated in Mass General about Relman and Angell's presence in the hospital: visiting royalty! Only a zealot for formal (as opposed to actual) democracy would assume that all are equal at MGH and that "professional courtesy," standing and reputation make no difference and thus Relman would be treated just like any other patient.

Relman is 90. After the emergency room, he was taken to the surgical intensive care unit. There, he writes, "my wife and our children all gathered very late that first night — three physicians and three lawyers, a company that in other hospitals might have bothered the hospital staff. But not here." Relman des not ask why this crowding was accepted in the MGH ICU, nor does he even speculate on the relevance to his care of the hospital's acceptance of the presence of this heavy medical/legal crowd. (There have been studies that see correlation between the quality of patient care and number

of visitors, albeit without attention to the prominence of the visitors.)

The treatment that Relmna got was by any definition heroic, and should be seen in the context of the contemporary notion that heroic measures are unwise, particularly for a 90 year-old patient. At one point in the ICU, Relman's heart stopped. "I would certainly have died then had it not been for the medical team." After two minutes of CPR and stimulants, Relman's heartbeat resumed. But then it stopped again. He was again given CPR, and within a minute, his heartbeat resumed. Again it failed, and again, after another minute of CPR, it resumed. "The resuscitation saved my life." It's hard to believe that this much energy is expended on 90-year olds with such grave multiple diagnoses who are not Arnold Relman. And apparently he wisely had not drafted a health care proxy which, if it follows the boilerplate phrasing available to all on the internet, authorizes doctors to cease resuscitation efforts if they deem the patient "incurable… with no reasonable expectation of recovery" – which certainly fits Relman's later characterization of his recovery as "astonishing." In another violation of standard healthcare proxies, he was put on a ventilator, apparently without the by now familiar ominous warnings that he might thus fall irretrievably into a persistent vegetative state. While healthcare proxies are presented as a way of carrying out the patent's preferences as considered in advance, such proxies only become operative in extremely coercive situations with life itself in the balance: doctors may be in a hurry to get elsewhere; their judgment may be subjective and inaccurate, and patients' families (if they are present) may be cowed by the doctor's expertise and the deference with which doctors are viewed. In a thousand informal ways, the message is conveyed to the sick old. These days we are propagandized through all media about the need to provide health care proxies, one of whose effects is to free doctors from suit for discontinuing life support – a discontinuation increasingly urged for the sick old whose duty to the nation in this age of cost/benefit driven medicine it is to get out of the way and die. But, contrary to this dominant ethos, "Physicians [at MGH]," Relman comments, "simply refused to let me die (try as hard as I might.") Are others beneficiaries of the kind of care that Relman received, or are they in some sense manipulated into giving up the struggle before it is absolutely necessary?

After his stay at Mass General, Relman was moved by ambulance to a private room at Cambridge's Spaulding Rehabilitation Hospital, which is affiliated with his health care insurance. Here, by his account, he received mixed to poor care in a noisy environment that interfered with sleep (Anyone who has experienced modern hospitalization –- including in our best institutions –- may find that the blaring noise of endless amplified announcements constitutes a significant health problem – an unexamined iatrogenic effect.) After many criticisms, Relman inexplicably concludes that his care at Spaulding was "superb." Then he moved with Angell to an apartment that they rented near Mass General. A physical therapist made frequent visits to the apartment while an extended stair lift was installed at home in Relman's condo. Relman offers no suggestion as to why he received such different care in the two hospitals. It seems reasonable to assume that he and Angell were better known at Mass General than at Spaulding, which is not as classy a place. (Another scholar speculates that while Relman was well known at Mass General, at Spaulding he would be seen as "just another old sick guy.")

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Relman's account of his hospitalizations misses the haloing effect of his professional visibility and prominence. In describing and analyzing his experience, Relman functions as a participant observer, but one of the first rules of social science is that observers must take into account the impact of their presence on the realities that they observe. Relman's omission eliminates from his analysis what may be the most important factor in determining the kind of care that he received – his standing and reputation (not to mention his easy access to publication on health care issues). And since he generalizes from his own experience, this omission seriously weakens his more general evaluation of health care in America.

“What,” asks Relman, “did this experience teach me about the current state of medical care in America?” “Quite a lot,” he answers, offering among his various sensible points that “costs are the central problem of the medical care system.” How sad to have come through all that and to have somehow missed the importance of privilege in medical care. Relman knows that he almost died a couple of times, and that the quality of his care was astonishingly good (at least at MGH). But what of the other patients? Speaking of his experience in the ICU he acknowledges the support that he had, particularly “the comforting presence of family and loved ones.” He sees that some of his fellow patients did not have the support that he had, and then concludes with optimistic speculation, “I can only hope that they received extra attention from their nurses. “ Relman offers no basis for this other than hope. Overall, the extra attention that Relman received saved his life.

When doctors hear about, or experience, the horrors of contemporary medical care, they tend to miss the systemic quality and explain it with the medical equivalent of, "there's a bad apple in every barrel" — an argument whose absurdity they may see when applied to police beatings of black youth, but whose absurdity they miss when applying it to medical care. In his implied argument – he received good care at Mass General because it is a top-notch place – he misses an important systemic consideration related to the place of hierarchy in the culture of the medical profession. As a (non-physician0 member of Physicians for a National Health Program, I am ardently for single-payer (“Medicare for All”),) but I don’t think this will change the culture of the medical profession, and, when finally enacted, single-payer will still leave untouched significant inequalities which can make the difference between life and death.

In many arguments that I have had over years within the left, I have always responded to the condemnation of “privilege” by noting that what is called privilege should not be taken away. Instead, everybody should be brought up to the level of the “privileged.”(Cf the question of tenure in academe.) I’m glad that Relman survived and received good care. He is a valuable human being, and it would be enough for him to be just a human being . But we will never get such care for all if we fail to face head on the problem of privileged access and different care for the privileged – these are aspects of the central problem of inequality in our society. Meantime, I’m going to ask Marcia Angell and Arnold Relman to accompany me when I’m next hospitalized – just for good luck. May all of us be so accompanied.

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