dear residents

Five Eras and Five Types of Patient Care **August 11, 2024**

Dear Residents,

I am attending on Clements Wards – and even though I fully expected high patient complexity – it seems even higher now. From when I began my medical training in 1980 to the present time, I have encountered at least five eras of patient care in which the patient mix and what we can do for them has substantially changed. What began as predominantly learning acute care medicine has expanded to include the need to learn preventive medicine, chronic disease management, complex disease management and palliative care. And all of this is wrapped up in an increased need to understand health system science and navigate the electronic health record.

Five Types of Patient Care:

Five Eras of Patient Care:

1. <u>1980's – medical school and transitional year in Pakistan</u>
   Most of my medical school training and experience was in the inpatient setting. These were essentially "single acute care episode" patients. We had admissions for pneumonia, stroke, GI bleeding, typhoid fever, malaria, tuberculosis, acute abdomen, childbirth, etc. Even in the outpatient setting, the patient mix was mostly urgent care: for rashes, wounds, fractures, asthma, respiratory infections, urinary tract infections, etc. I do not think there was any space for "proactive health seeking" and it was certainly not something that people thought about every day. There were not any established screening programs or any public service campaigns other than for childhood vaccination. There was no direct marketing from the pharmaceutical industry to patients. People sought healthcare when something went acutely wrong. And people died at home. That was often the first question someone asked us because there was a prevailing cultural construct regarding the dignity of dying in one's own home. If someone looked like they were near the end, the family preferred to take them home. Accordingly, palliative care was not a thing (at least not an inpatient thing).
2. <u>Late 80's – internal medicine residency in Houston</u>
   Things were of course dramatically different in Houston compared to Pakistan. We could do a lot more for each patient - especially more imaging and more lab work than I had ever experienced. For me, the more notable difference in the patient mix was cancer, end-stage renal disease and coronary artery disease. It is

not that these things did not exist in Pakistan at the time but given that cancer was primarily a surgical specialty, and that dialysis was hard to come by and that coronary disease was rare (it has since exploded in South Asia) we did not see much of this. Oncology, nephrology, and cardiology became important parts of my training in residency. But again, most of my experience was in the inpatient setting (advanced cancer, ESRD and acute coronary syndromes respectively). Until the start of my residency, I had never taken care of a patient with sickle cell anemia. And I also had my very first experience with the care of patients with AIDS. The ICU was unfamiliar to me as I embarked on the challenging journey of learning complex acute care. If there was palliative care, it did not have that name. We were proactive DNR seekers and had some experience with withdrawal of care when confronted with medical futility. I had a weekly primary care longitudinal clinic where we generally saw the typical triad of diabetes, hypertension, and hyperlipidemia. It was chronic disease management with a concise therapeutic armament.

3. 1990's – rheumatology fellowship in Houston
   Fellowship was a time when I developed some expertise in the relatively uncommon connective tissue diseases but acquired, for the first time, the skills required for the longitudinal care of chronic diseases like rheumatoid arthritis. In residency, clinic was something that came in the way of your primary responsibility which was the care of the hospitalized patients. In residency, clinic occurred one half day a week - it did not matter if you were on-call or post call. The only 2 rotations that you were excused from clinic were the ICU and the emergency room. And the only 2 excuses for not showing up in clinic were death or near death. Rheumatology fellowship was more predictable than residency training. We had clinic every morning and consults every afternoon. We slept every night.
4. 1995-2000 - early attending experience in Dallas
   I experienced the impact of the UT Southwestern resident. Even though I was supposedly their supervisor, it was clear that these were very talented people. When I came on to the faculty, John Warner and James de Lemos were the two chief residents. Darren McGuire, Craig Glazer and Elizabeth Paulk were current residents. These were high performing people (as they are today!). The residency program was essentially Parkland and the VA - with several inpatient teams on both sides. There were no team caps, no admission limits and barely 1 day off in 7. It was not until 2003 that ACGME developed standards for resident work hours and days off. Residency training during this period was still very acute care based but importantly there was a balanced mix between single acute care episodes and complex acute care. Rheumatology underwent a dramatic change in the late 1990s with the onset of biologic therapy for rheumatoid arthritis. This advance subsequently spread to several other autoimmune conditions such as psoriasis, inflammatory bowel disease, multiple sclerosis, etc.
5. 2010 – now
   Over the last decade and a half, we have experienced a shift towards complex acute care, complex chronic care, and palliative care. This coincides with remarkable developments in oncology, heart failure and transplant medicine. Much more can be done for so many more conditions. Hepatitis C can be cured, HIV is now a chronic illness, people actually survive cancer, there are immune-based therapies for a whole host of diseases and almost every organ can be transplanted. There is much more emphasis on physician wellbeing, patient centered care, patient safety and high value care. We are now just beginning to pay attention to healthcare disparities and to physician advocacy. Today's resident must be prepared for so much more. Today's attending is now a "silver resident" - just trying to keep up with the intersection of complex chronic diseases, new treatment guidelines and novel drugs. Lifelong learning is no longer just an option - it is an absolute necessity. The attending is no longer the repository of knowledge (knowledge is now fully democratized and freely available online). I think my main value to the team is to build trust with patients, manage their expectations, resolve their conflicts with the Dilaudid dose, and help facilitate communication with consultants. I am more a team psychologist than anything else! I do still love teaching the physical exam.

You will write your own chronicles – there is unimagined change coming. Will generative artificial intelligence radically change how we deliver care, or will it just be another tool that looked promising but ultimately didn't move the needle forward? Will private equity buy up all of medicine, or will we have universal healthcare? Will we keep spending most of our resources on clinicism or will we finally tackle social determinants of health.

As Buckingham states: *The thing we call "planning" doesn't tell you where to go; it just helps you understand where you are*.

We are in a good place. Having trained elsewhere, I can assure you that very few places have what we have here. Where we go from here is unknown, but our history at UT Southwestern is a remarkable one that promises an optimistic future.

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