web eXtras

JAMA
The Journal of the American Medical Association
Vol. 252, pp. 819-820, Aug. 10, 1984

Francis Peabody's "The Care of the Patient"*

*Pauline L. Rabin, MD; David Rabin, MD***

This classic essay, with its fabric of pristine humanism, its universality, and its timelessness, embodies the noblest aspirations of the medical profession. Peabody gave his address at the Harvard Medical School during a course on the care of the patient. Dr Joseph Pratt (1) was in the audience and subsequently wrote: "After the lecture I talked with Dr. Peabody. His address doubtless made a deep impression on the audience but there was no evidence of unusual approval. In a few minutes the hall was emptied and we were alone." Since that day in 1926, Peabody's words have become a paradigm for all physicians.

On the Patient as Person

His essay covers three chief topics. The first is the importance of individualizing medical care. Long before the introduction of the SMAC 46 battery, to which so many patients are subjected even before they see their physician, Peabody cautioned the medical profession in the following words: "the essence of the practice of medicine is that it is an intensely personal matter.... The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it...." This philosophy was already deeply ingrained in Peabody while still a medical student. In 1906, addressing the Boylston Medical Society on the treatment of diabetes, he said: "We must not forget in treating diabetes that we are treating a man and not a disease" (2).

The following example bears out Peabody's message. A patient with cancer of the breast had great confidence in her oncologist. She was, however, concerned about metastases and was becoming increasingly depressed. Whenever she asked him a question about her illness, he would give her an answer based on statistical results from the literature. The patient inferred from this that to him she was no more than an impersonal dot in a computer printout. Clearly, statistical information is extremely valuable. The physician, however, should not hide behind numbers to avoid dealing with the patient's underlying anxiety that prompts such questions.

His second concern is a call to awareness about the dehumanizing experience that so often accompanies hospitalization. Peabody displays remarkable insight into the forces that tend to depersonalize the patient who enters a hospital. He emphasizes the difficulties of getting to know the patient as an individual in a hospital setting. These features have been magnified during the past 60 years. As soon as a patient is registered in a medical center today, his entire past record and laboratory data can be obtained by punching the correct code into a computer. This, of course, provides invaluable information. The various teams of consultants and even the patient's personal physician and resident may become so absorbed in receiving the computerized information that they may spend less time with the patient. These realities can be overcome by adherence to Peabody's credo: "What is spoken of as a 'clinical picture' is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears. Now, all of this background of sickness which bears so strongly on the symptomatology is liable to be lost sight of in the hospital ...." These concerns apply equally to current private practice. Peabody was the great champion of the general practitioner who knew the patient and his family intimately. Today, house calls are virtually obsolete and patients may be seen by a succession of specialists, none of whom has a clear picture or understanding of the man or woman who is the patient.

His third topic is the care of patients who have symptoms for which an organic cause cannot be determined. Peabody devotes a considerable segment of his essay to improving the attitudes of physicians to patients who do not show objective, organic pathological conditions and who are generally spoken of as having "nothing the matter with them." Peabody thought that this group of patients constituted up to half of any physician's practice, and this is probably true today. It is known that the majority of antidepressants and minor tranquilizers are prescribed by nonpsychiatrists. Peabody advocates an approach that includes a thorough knowledge of psychological factors operative in the patient's life. This can only be obtained by spending time with the person and gaining his confidence about intimate personal history.

Rather than communicating to the patient that there is "nothing the matter," one should take the time to explain "how it is that emotional states may bring about symptoms similar to his own." It has been well documented that educating patients about their illness and about psychological issues is an inherent and critical part of all medical treatment. Today, this approach is appreciated as an important adjuvant in the care of the patient, especially those patients with chronic diseases.

Dr Peabody's Example

When we initially read this article, we were inspired by the clinical sensitivity linked with scientific perspective but were surprised by an omission of a discussion on the role of the physician with terminally ill and dying patients. Jacob Bigelow, addressing a group of medical students in 1858, had described the duties of a physician to encompass diagnosis, treatment, the relief of symptoms, and the provision of safe passage (3). By "safe passage" is meant the support and ready availability of the physician to his or her patient until death (4). Although Peabody did not actually discuss the terminally ill in his famous address, he was

communicating another important message regarding this subject to his audience by his very presence there. It was known that he was at that time suffering from an inoperable cancer. Yet, he continued to function, teach, and care for his patients as long as he was able. Thus, he was an example of how a person can accept illness and live alongside it with dignity and purpose. Although the quantity of life granted to him was short (he died at the age of 47 years), the quality of his life was enriched by his dedication to his work, his devotion to his family, and the support he received from his friends. Langdon Warner (5), a lifelong friend, was moved to write his account of those remarkable visits:

> You came hesitating, perhaps, and wondering how you could stand it. But you smoked, gossiped and reported the news; discussed a marriage, birth or a death; told your troubles, took some of the invalid's grapes, and left. There had been no sad-eyed bravery about it, no attempt to ignore the obvious. And all this time when our hearts were standing still with the pity of it, his task was gently to show us that there was no need for horror.

There have been dramatic changes in medicine in the nearly 60 years since Peabody died. Much would have delighted and perhaps even amazed him. We suspect, however, that he would have viewed some of the changes with deep apprehension. The cost of medical care now approaches 300 billion dollars annually or 10.5% of the gross national product, and, despite this staggering figure, good medical care is not readily available to all citizens (*New Republic* April 18, 1983, p 19). In 1923, he wrote:

> The primary function of a municipal hospital is without question, to provide the best care for the sick poor of the city.... The municipal hospital must be prepared at all times to admit any and every citizen genuinely in need of medical aid.... In a municipal institution, even more than in a private institution, there is need for trained social workers. The duty of the city towards the health of its citizens certainly extends beyond the walls of the hospital (6).

Today, the care of the poor and those without adequate medical insurance is delegated to the already overburdened general hospitals, which are supported by increasingly depleted municipal funds. Some city hospitals, in fact, have been forced to close. The health plight of the poor is becoming critical.

How would this man who chose Boston City Hospital over choice appointments at Johns Hopkins, Yale, and Stanford have viewed the burgeoning hospital-for-profit phenomenon? How would this man who spent the last days of his life completing an essay on the soul of the clinic have reacted to the marketing of health care by enormous corporations (7)? He would surely have been exercised by the growing medical needs of the chronically ill and the aged and by a nursing home population of 1.3 million that is expected to climb to 2 million within a decade. Nor would he have avoided confronting the awesome ethical dilemmas that face physicians engaged in the care of chronically ill, debilitated patients in nursing homes (8).

In all probability, he would have shared Lewis Thomas' concern about the widening gap between the physician and his patient and might well have commended Thomas'

(9) turn of phrase, "Medicine is no longer the laying on of hands, it is more like the reading of signals from machines." He certainly would have agreed also with Thomas' concern for the changing nature of the medical profession today. Writes Thomas, "If I were a medical student or an intern, just getting ready to begin, I would be apprehensive that my real job, caring for sick people, might soon be taken away, leaving me with the quite different occupation of looking after machines."

Peabody's scientific contributions were outstanding. Had he lived another few years, it is very possible that he would have shared with his friend Minot the Nobel Prize for the discovery of liver therapy for pernicious anemia. Nevertheless, his legacy to medicine is eternal. He was the compleat physician, clinical scientist, teacher, healer, counselor, confidant, and friend to his patients.

* A commentary on Peabody F: The care of the patient. *JAMA* 1927;88:877-882.

** From the Departments of Medicine (Dr D. Rabin) and Psychiatry (Dr P. L. Rabin), Vanderbilt University School of Medicine, Nashville, Tenn.

References

1. Pratt JH: The personality of the physician. *N Engl J Med* 1936;214:364-370.

2. *Boylston Medical Society Records*, 1899-1908, pp 307-308.

3. Krant J: *Dying and Dignity*. Springfield, Ill, Charles C Thomas Publisher, 1974, p 60.

4. Bigelow J: *Brief Exposition of Rationale Medicine*. Boston, Phillips, Sampson and Company, 1858.

5. Warner L, quoted by Peabody FG: *Francis Weld Peabody, 1881-1927, a Memoir*. Cambridge, Mass, Riverside Press, 1933, pp 69-70.

6. Peabody FW: The function of a municipal hospital. *Boston Med Surg J* 1923;189:125-129.

7. Peabody FW: The soul of the clinic. *JAMA* 1928;90:1193-1197.

8. Hilfiker D: Allowing the debilitated to die. *N Engl J Med* 1983;308:716-719.

9. Thomas L: *The Youngest Science*. New York, Viking Press Inc, 1983.

top

Table of Contents

HOME ARTICLES RESOURCES SEARCH FEEDBACK PAST ISSUES JAMA home page AMA home page
NEWS/ANNOUNCEMENTS CAREER EDUCATION STUDENT LOUNGE AMA-MSS LINKS E-MAIL ALERT SERVICE