Understanding the Dynamics of Health—A Systematic Person-Centered Approach

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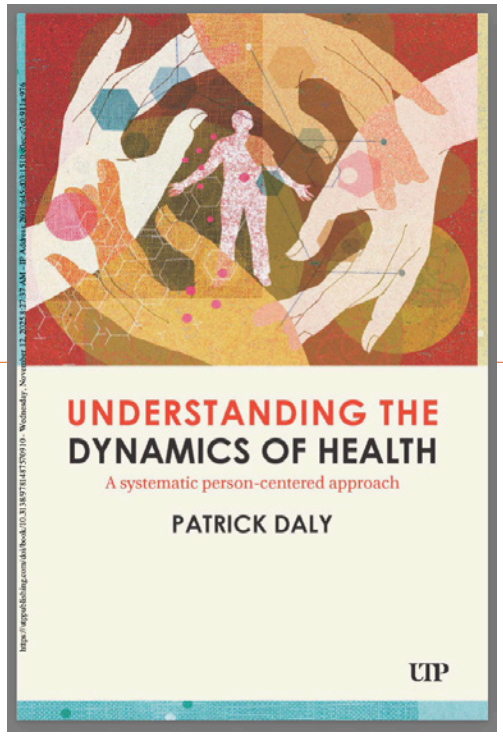
Rhode Island resident **PATRICK DALY, MD, MA**, a research associate at the Lonergan Institute at Boston College, published a book in November, *Understanding the Dynamics of Health—A Systematic Person-Centered Approach*. It is available on the publisher's website at: https://utppublishing.com/doi/book/10.3138/9781487570910.

The website describes the book as developing "a comprehensive framework for understanding health and its impairments, drawing on the work of philosopher Bernard Lonergan. Providing a systematic and critical foundation for uniting diverse health-related disciplines, from network biology and neuroscience to narrative medicine, bioethics, and public health philosophy, this book's holistic framework not only emphasizes the lived experience of the whole person but also establishes a methodological approach for integrating the ever-expanding fields of health science and healthcare."

I asked Dr. Daly to respond to a Q&A, to offer some insights into his background and the journey to publication of this book.



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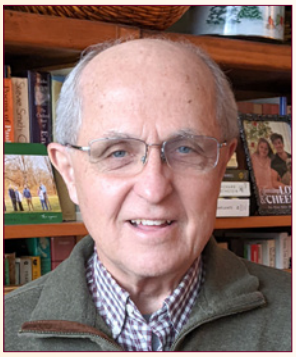

PATRICK DALY, MD, MA

- BS, Providence College, 1969
- MD, Northwestern University Medical School, 1974
- Residency, internal medicine, Washington DC VA Medical Center, 1974–1977
- Practiced primary care/internal medicine in South Kingstown and Narragansett, 1977–2000; and then from 2000–2012 in Bangor and Augusta with VA Maine, where, following subspecialty certification, became Director of Hospice and Palliative Care from 2008–2012
- MA, philosophy, Boston College, 2013
- Current: Research associate, Lonergan Institute at Boston College

Q. What led you into the field of medicine after graduation from Providence College (PC)?

A. While I was still in grammar school, when asked, I would say that I wanted to be a psychiatrist. I probably got this idea at the age of four when my father went away for psychiatric treatment, thinking if psychiatrists were going to make my father better, I wanted to become a psychiatrist. Another formative experience was when my grandfather, who lived with us, became ill and died shortly after, my parents did not answer my questions about what was obviously a serious situation or allow me the chance to say goodbye. This later fed into my interest in palliative care. At PC, I found out that I liked biology, which eventually led me to choose internal medicine and to attend to the whole person in my medical career.

Q. On Mentorship: Who influenced you the most in your burgeoning career and why is mentorship key?

A. I admired my pediatrician growing up, who encouraged me to pursue my plans to go to medical school and become a doctor. I admired his direct and careful approach to what he said and what he was doing. I would have to say during internship and residency, it was the whole atmosphere of teaching and learning at the Washington DC VA Medical Center, under the leadership of Dr. Hyman Zimmerman, that excited me and gave me a sense of what it means to be a good doctor. The noontime conferences there were a highlight of my training. When I first started to practice in South County, I benefited from the wise counsel of a senior physician there, Dr. Thomas Nestor.

Q. You practiced as an internist in South Kingston and Narragansett after your residency for decades. Can you briefly describe from your vantage the shifting sands of medical practice for the individual practitioner – the then and the now.

A. I began as a solo practitioner in Wakefield in 1977 and had a coverage arrangement with two other young internists. At that time, we submitted third-party insurance claims by snail mail. Covering the emergency room for medical admissions at South County Hospital and the resulting interruption of our office schedules was a major challenge, especially during the summer months with the influx of tourists. Since then, the medical

community in South County has grown and expanded to include medical specialists, mid-level practitioners, and hospitalists. More generally, urgent care centers have sprung up, practices have become computerized (first for billing and now for the clinical record), and the insurance, pharmaceutical, and regulatory climate have gotten dramatically and financially more complex. All of these changes, along with the educational debt that new practitioners carry, favor large group practices that have the scale to negotiate with large corporate entities. What happens to patients, financially and clinically, in our current situation remains a vexing question.

Q. The VA system provides essential/critical care for Veterans, not only here in Providence and throughout New England, where you practiced in its system, but nationwide. Its scope has expanded. How did working within the system further influence your career trajectory?

A. I left private practice to join the VA in order to concentrate more on clinical care and less on financial matters. I also valued the underlying moral understanding that Veterans are due good medical care in exchange for the service that they have rendered to the country. I think this understanding could be generalized to require one-two years of public service (military or non-military) of all citizens entering adulthood in exchange for universal healthcare. As far as my career trajectory, through the support and training that the VA provided, I became board-certified in Hospice and Palliative Medicine and helped to develop a palliative care service for Maine veterans and an inpatient hospice unit at the Togus VA Medical Center.

Q. You served as a palliative care physician. Can you relate one or two experiences that shifted your perspective on end-of-life issues.

A. As I mentioned, I was motivated to be truthful about delivering bad news by my experience of my parents being evasive about my grandfather's illness when I was twelve. But I learned that some patients, who are not in denial about their condition, still do not want to hear a sentence of death from their doctor. It is so important to learn how the patient understands what is going on and what they expect or hope for from us and to adjust what we say accordingly. For instance, to say, "I am not sure we can fix this, but here is what we can do," instead of, "You are dying and you only have three months to live." On a positive note, the relationship of caring is the most important element of palliative care and nursing assistants are often the best models of this fact.

Q. You transitioned from a medical career to philosophy to your current position at Boston College. Would the young Dr. Daly recognize the person he has become today?

A. Yes, he would. I have wanted to write since I was in my teens. I admired Anton Chekhov and William Carlos Williams for combining writing and medical careers. When I was younger, I tried my hand at poetry and playwriting. My closest encounter with success along those lines was a concert reading in Kingston and Newport, RI, of Five Needles, White Pine, an opera-musical for which I wrote the libretto and Geoffrey Gibbs wrote the music. Then things lay fallow until I discovered Bernard Lonergan's work in my fifties. He answered many questions that I had long hoped to answer. After taking an MA in philosophy at Boston College in 2013, I set out to develop a philosophy of health based on Lonergan's work because I think that he understands the relationship between science and art in a way that resonates profoundly with the relation between health science and healthcare. ❖

Book Excerpt

The following is an excerpt from the book illustrating one patient's experience.

(Chapter 9.2) The Clinical Encounter: An Illustrative Story

In *Our Malady*, Timothy Snyder tells a personal story of his encounter with modern health-care systems in Germany and the United States in late 2019 and early 2020 when he nearly died from sepsis following a delayed diagnosis and operation for appendicitis. He first presented with abdominal pain to a hospital in Munich, Germany, on December 3, 2019, where he was admitted overnight for observation and released the next morning with a diagnosis of viral gastroenteritis. Neither a computerized tomographic (CT) scan nor antibiotics were performed or recommended at that time.

After returning home to New Haven, Connecticut, his symptoms worsened. On December 15, he underwent an appendectomy for a ruptured appendix at a university hospital and was discharged home the following morning with a short course of oral antibiotics. An abdominal CT scan at that time showed a liver lesion, which did not come to the attention of his treating physicians until two weeks later.

On December 23, while visiting for the holidays with family in Florida, he developed tingling and numbness in his hands and went to a local hospital where he was evaluated neurologically, observed overnight, and released the next day without a clear diagnosis. Over the next few days, he became increasingly weak and fatigued.

On December 28, he flew back to Connecticut with his family to seek care closer to home. A friend met them at the airport in Hartford and drove him to the emergency department of the hospital in New Haven, while Snyder's wife took care of the children and the luggage. He arrived about midnight on

December 29 and lay in a cot in extremis for the next seventeen hours competing with other patients in the busy emergency department for the attention of nurses and physicians. After finally persuading them that his illness had something to do with his appendectomy at this same hospital two weeks before and getting them to review his records, they repeated his abdominal CT scan and realized that he had a liver abscess and was now septic. A catheter was placed to drain the abscess, and he was started on intravenous antibiotics. He subsequently required the placement of two more drains to fully clear the abscess. After being discharged home, he continued antibiotic treatment for several weeks and finally returned to work on a limited basis toward the end of March 2020.

Clinical Conversation

The author follows this "case report" with a "Clinical Conversation."

…Timothy Snyder lived to tell his story so, in that respect at least, he exemplifies the self-correcting nature of the cycle of figuring out what was wrong with him and what needed to be done. In the acute care setting, the initial assessment of the severity of a situation typically dictates the flow of the patient's care within the overall flow of care in that setting – what tests are done, how quickly, what treatments are started, who is consulted, whether hospitalization is indicated, and the like. This initial assessment is largely based on common sense – what this practitioner (however skilled, tired, or distracted) makes of this patient (however reserved, agitated, or clear minded). Although Snyder's findings warranted overnight observation in Munich, his stoic demeanor in concert with the doctors' cultural preference to avoid excessive exposure to radiation apparently led to the decision not to do a CT scan. Two weeks later in New Haven, the decision to operate went smoothly so far as we know, but, in retrospect, the decision to discharge him home the next morning was premature. The scene that Snyder describes in the emergency department in New Haven on December 29 was chaotic. Whether or not staffing was an issue, the staff's snap judgments – some that may have been racially prejudiced concerning the female physician and friend who accompanied him – and the piecemeal and often dismissive style of communication delayed appropriate assessment and treatment decisions for hours. Absent appropriate attentiveness, the self-correcting cycle of learning grinds to a halt, while, in cases like this one, the patient's condition continues to worsen.