If you had been a few feet away, you would have never guessed she was nearly 50 years old. She looked more like a child, her tiny silhouette hiding beneath the bleached-white hospital sheets. A brightly colored cloth wrapped her hair, further concealing her years. Only temporal wasting and paper-like thinning of the caramel-colored skin over her cheekbones betrayed her age and illness.

I met Ms. Lana as I would come to call her, while on-call as a medical student. As a third-year medical student, you are always hoping to get the “perfect patient”… the one who gives you a clear, concise history, the one who makes you look good in front of your team, and the one who does not mind you rudely waking them for morning rounds. At first Ms. Lana seemed anything but the “perfect patient.” When I entered her room for the admission interview, she could not have seemed less interested. She did not open her eyes throughout the encounter; she mumbled faint responses laced with irritation to only a sporadic selection of my questions.

Most of what I knew about Ms. Lana that first day I gleaned from her extensive hospital records. She had been admitted to our health system 12 times over the previous 5 years, the past 10 admissions being for recurrent abdominal pain and nausea secondary to diabetic gastroparesis. She had had 13 abdominal/pelvic CT scans with contrast and four ultrasounds of the abdomen. All imaging tests had been negative except imaging years ago that had shown gall stone pancreatitis and cholecystectomy. Multiple X-rays of her abdomen, an upper gastrointestinal series, a small bowel follow-through, an upper endoscopy and a colonoscopy – all had been unrevealing. Two gastric emptying studies showed mild gastroparesis, Ms. Lana had been non-adherent with the pro-motility agent that had been repeatedly prescribed, and had over the course of several hospitalizations become dependent on oxycodone, which would exacerbate her motility issues. Her illness was further complicated by HIV, hepatitis C, depression, alcohol abuse, and intermittent cocaine use.

Our attending had actually taken care of Ms. Lana twice before. Her abdominal pain and nausea would be controlled at each admission, and after discharge she would not take her pro-motility agents or follow through with HIV and substance use care. At first,
this admission seemed no different. She was emaciated at 70 lbs, down 38 lbs from when our attending had seen her last. Her urine was positive for cocaine, though she denied using it, and she was requesting narcotics to manage her abdominal pain.

The morning after admission our team considered the sensitive issues Ms. Lana faced and debated whether we should present her case at the bedside, as was our custom on rounds. Our medicine team that month was part of the Aliki Initiative, a novel pilot project at Johns Hopkins Bayview Medical Center. The case load for our team was halved, with the directive that we get to know our patients better and address their often complex social needs during and after their hospital stay.

I knew that counseling would be invaluable to Ms. Lana's care, but I was not confident in my own ability to traverse the fine line between acceptance and gentle confrontation in addressing her medication non-adherence, cocaine use, and narcotic dependence. I tried to talk my way out of presenting at the bedside, but my resident and attending would not let me off the hook. Our team decided that given Ms. Lana's recidivism, it would be best to discuss all of these issues with her as openly, honestly, supportively, and inclusively as possible, which could be done privately with her in her single room.

While presenting Ms. Lana's case, I could not be sure if she was hearing me, as her eyes were initially closed. I leaned over the plastic bedrail and held her hand, while the rest of the team, who had also met with her the previous evening, formed a circle around her. At one point Ms. Lana's eyes opened and looked at me. We talked about gastroparesis and explained our rationale for dietary adjustments and pro-motility agents like metoclopramide. We talked about how oxycodone, which she had come to depend on, was actually making her stomach troubles worse. We talked about cocaine and how it would also affect her appetite. We talked about HIV and how there were medications that she could take to keep her immune system strong. Her right hand, which had previously been limp, squeezed mine, signaling that she was hearing and connecting with us. Our attending looked at Ms. Lana and said, "We know that life has not been fair to you. You've been dealt a bad hand of cards. We're just going to try to deal you one good hand."

I think that made all the difference. With this simple, yet empathic statement, our attending set the tone for the many conversations that would follow with Ms. Lana. And for me personally, he modeled our responsibility as healthcare providers to discard preconceived ideas, seek understanding, and offer acceptance and support. We went on to lay out a plan for the hospitalization with Ms. Lana's full involvement. What followed surprised us all. Over the coming days, we learned more about Ms. Lana's life. We learned that she lost both of her parents at age 7 and had been raised in a series of foster homes. Whenever I came into her room, Ms. Lana insisted that I sit down and watch television with her. We watched segments of the Godfather and lamented together Fredo's betrayal of Michael Corleone. Ms. Lana was positive for cocaine, though she denied using it, and she was pregnant two days after admission. The next day her urine was positive for cocaine, though she denied using it, and she was pregnant. We believed so. She gained a much improved health status and happiness. Her recidivism rate was markedly reduced, and she became successful at managing several chronic illnesses and a complex medication regimen. Getting to know Ms. Lana was not only a privilege; she was my ultimate teacher, better than the "perfect patient." She taught me, as an impressionable third-year medical student, what kind of doctor I wanted to be and what makes a great patient.

Two and a half years after discharge from our service, Ms. Lana was doing well, and in her own apartment. Yes, Ms. Lana was doing well, and in her own words "fat as a butterball." We met her in her very tidy apartment cooking fried chicken, which impressively she could now eat. She had been off cocaine and all narcotics for over 2 years, was attending a Narcotics Anonymous and Alcoholics Anonymous meetings, saw her health care providers regularly, and was managing all of her medications on her own, including insulin. She also had a boyfriend and went dancing on Friday nights in a nearby church basement. She was delighted to see us and felt proud to report that she was on "cloud nine".

A follow-up phone call five years after discharge revealed that Ms. Lana was still doing well, living independently, and had only one hospitalization since we cared for her. We provided Ms. Lana with personalized care. We also delayed discharge until we knew she had a safe place to stay and communicated personally with individuals who would provide care for her going forward. We may not have had the time or capacity to provide this kind of care and follow-up had the Aliki service not reduced our caseload. Was Ms. Lana's care cost-effective? We believe so. She gained a much improved health status and happiness. Her recidivism rate was markedly reduced, and she became successful at managing several chronic illnesses and a complex medication regimen. Getting to know Ms. Lana was not only a privilege; she was my ultimate teacher, better than the "perfect patient." She taught me, as an impressionable third-year medical student, what kind of doctor I wanted to be and ultimately led me to pursue a path in psychiatry, where getting to know patients is paramount. All of us who worked with Ms. Lana learned something about our own humanity. We felt really good about being physicians.

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