EDITORIAL

The Worst and the Best of 2019

Suffering is only intolerable when nobody cares. One continually sees that faith in God and his care is made infinitely easier by faith in someone who has shown kindness and sympathy.
Dame Cicely Saunders[1]

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Readers may recall that at the end of each calendar as opposed to fiscal year—I know it is hard to believe time exists outside the Federal system—*Federal Practitioner* publishes my ethics-focused version of the familiar year-end roundup. This year I am reversing the typical order of most annual rankings by putting the worst first for 2 morally salient reasons.

The first is that, sadly, it is almost always easier to identify multiple incidents that compete ignominiously for the "worst" of federal health care. Even more disappointing, it is comparatively difficult to find stories for the "best" that are of the same scale and scope as the bad news. This is not to say that every day there are not individual narratives of courage and compassion reported in US Department of Defense, US Public Health Service, and US Department of Veterans Affairs (VA), and hundreds more unsung heroes.

The second reason is that as human beings our psychology is such that we gravitate toward the worst things more powerfully and persistently than we do the best. This is in part why it is more difficult to find uplifting stories and why the demoralizing ones affect us so strongly. In an exhaustive review of the subject, psychologists Roy Baumeister and colleagues conclude that,

> When equal measures of good and bad are present, however, the psychological effects of bad ones outweigh those of the good ones. This may in fact be a general principle or law of psychological phenomena, possibly reflecting the innate predispositions of the psyche or at least reflecting the almost inevitable adaptation of each individual to the exigencies of daily life.[2]

I am thus saving the best for last in the hope that it will be more memorable and impactful than the worst.

Unique to this year's look-back, both the negative and the positive accounts come from the domain of end-of-life care. And unlike prior reviews where the lack of administrative vigilance and professional competence affected hundreds of patients, families, and staff, each of this year's incidents involve a single patient.

An incident that occurred in September 2019 at a VA Community Living Center (CLC) in Georgia stood out in infamy apart from all others. It was the report of a veteran in a VA nursing home who had been bitten more than 100 times by ants crawling all over his room. He died shortly afterward. In a scene out of a horror movie tapping into the most primeval human fears, his daughter Laquana Ross described her father, a Vietnam Air Force veteran with cancer, to media and VA officials in graphic terms. "I understand mistakes happen," she said. "I've had ants. But he was bit by ants two days in a row. They feasted on him."[3]

In this new era of holding its senior executive service accountable, the outraged chair of the Senate Veterans Affairs Committee demanded that heads roll, and the VA acted rapidly to comply.[4] The VA Central Office placed the network director on administrative leave, reassigned the chief medical officer, and initiated quality and safety reviews as well as an administrative investigative board to scrutinize how the parent Atlanta VA medical center managed the situation. In total, 9 officials connected to the incident were placed on leave. The VA apologized, with VA Secretary Robert Wilke zeroing in on the core values involved in the tragedy, "This is about basic humanity and dignity," he said. "I don't care what steps were taken to address the issues. We did not treat a vet with the dignity that he and his family deserved."[5] Yet it was the veteran's daughter, with unbelievable charity, who asked the most crucial question that must be

answered within the framework of a just culture if similar tragedies are not to occur in the future, "I know the staff, without a shadow of doubt, respected my dad and even loved him," Ross said. "But what's their ability to assess situations and fix things?"[3]

To begin to give Ms. Ross the answer she deserves, we must understand that the antithesis of love is not hate but indifference; of compassion, it is not cruelty but coldness. A true just culture reserves individual blame for those who have ill-will and adopts a systems perspective of organizational improvement toward most other types of errors.[6] This means that the deplorable conditions in the CLC cannot be charged to the failure of a single staff member to fulfil their obligations but to collective collapse at many levels of the organization. Just culture is ethically laudable and far superior to the history in federal service of capricious punishment or institutional apathy that far too often were the default reactions to media exposures or congressional ire. Justice, though necessary, is not sufficient to achieve virtue. Those who work in health care also must be inspired to offer mercy, kindness, and compassion, especially in our most sacred privilege to provide care of the dying.

The best of 2019 illustrates this distinction movingly. This account also involves a Vietnam veteran, this time a Marine also dying of cancer, which happened just about a month after the earlier report. To be transparent it occurred at my home VA medical center in New Mexico. I was peripherally involved in the case as a consultant but had no role in the wondrous things that transpired. The last wish of a patient dying in the hospice unit on campus was to see his beloved dog who had been taken to the local city animal shelter when he was hospitalized because he had no friends or family to look after the companion animal. A social worker on the palliative care team called the animal shelter and explained the patient did not have much time left but wanted to see his dog before he died. Working together with support from facility leadership, shelter workers brought the dog to visit with the patient for an entire day while hospice staff cried with joy and sadness.[7]

As the epigraph for this editorial from Dame Cicely Saunders, the founder of the modern hospice movement, says, the difference between unspeakable pain and meaningful suffering can be measured in the depth of compassion caregivers show to the dying. It is this quality of mercy that in one case condemns, and in the other praises, us all as health care and administrative professionals in the service of our country. Baumeister and colleagues suggest that the human tendency to magnify the bad and minimize the good in everyday myopia may in a wider vision actually be a reason for hope:

> It may be that humans and animals show heightened awareness of and responded more quickly to negative information because it signals a need for change. Hence, the adaptiveness of self-regulation partly lies in the organism's ability to detect when response modifications are necessary and when they are unnecessary. Moreover, the lessons learned from bad events should ideally be retained permanently so that the same dangers or costs are not encountered repeatedly. Meanwhile, good events (such as those that provide a feeling of satisfaction and contentment) should ideally wear off so that the organism is motivated to continue searching for more and better outcomes.[2]

Let us all take this lesson into our work in 2020 so that when it comes time to write this column next year in the chilling cold of late autumn there will be more stories of light than darkness from which to choose.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

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LETTERS

VA Ketamine Controversies

To the Editor: We read with interest the editorial on the clinical use of intranasal esketamine in treatment-resistant depression by Editor-in-Chief Cynthia Geppert in the October 2019 issue of *Federal Practitioner*.[1] A recent case report published in your journal illustrated the success of IV ketamine in alleviating refractory chronic pain caused by a rare disease.[2] Ketamine has been well established as an appropriate adjuvant as well as an alternative to opioids in attenuating acute postoperative pain and in certain chronic pain syndromes.[3] We write out of concern for the rapidity of adoption of intranasal esketamine without considering the merits of IV ketamine.

When adopting new treatments or extending established drugs for newer indications, clinicians must balance beneficence and nonmaleficence. There is an urgent need for better treatment options for depression, suicidality, posttraumatic stress disorder (PTSD), and chronic pain in the veteran population. However, one must proceed with caution before wide adoption of a treatment that lacks real-world data on sustained or long-term benefits.[4] Enthusiasm for this drug must also be tempered by the documented adverse effect (AE) of hepatic injury and the lack of data tracking this AE from repeated, long-term use.[5] With these considerations in mind, reliable dosing and predictable pharmacokinetics are of great importance.

In addition to outpatient esketamine, outpatient IV administration of racemic ketamine remains an advantageous option with unique benefits compared with esketamine. Pharmacokinetically, IV ketamine is superior to intranasal esketamine. The bioavailability of intranasal esketamine is likely to be variable. A patient with a poor intranasal application or poor absorption might be falsely labeled an esketamine nonresponder. Increasing intranasal esketamine dosage to avoid false nonresponders may place other patients at risk for overdose and undesired AEs, including dysphoria and hallucinations. The variable bioavailability of intranasal ketamine adds complexity to the examination of its clinical effectiveness. IV ketamine should provide a predictable drug level and more reliable data. One might retort that esketamine is not the same as ketamine. True, esketamine is the S-enantiomer of ketamine, whereas ketamine is a racemic mixture of S- and R-ketamine. However, there is no clear evidence of clinically relevant differences between these formulations.[5]

Psychomimetic effects and cardiovascular changes are the most common short-term AEs resulting from ketamine.[5] An IV infusion allows the treating physician to slowly titrate the administered ketamine to reach an effective concentration at the target site. Unlike an all-or-none intranasal administration, an infusion can be stopped at the first appearance of an AE. Psychomimetic effects, such as hallucinations, visual disturbances, and dysphoria are thought to occur in a