



Editorial

Notes From Cardiology Clinic: Medicine Is More Than Just Pills, Procedures, and Devices

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See article by Waters, pages 1294–1295 of this issue.

The physician should not treat the disease but the patient who is suffering from it.

—Moses Maimonides (1135-1204)

How often we forget this adage in medicine. I remember when I was a cocky Straight Internal Medicine Intern functioning as the Internal Medicine Resident on Call at the dearly beloved and sadly demised Queen Elizabeth Hospital in Montreal. I admitted a patient from the emergency department to the intensive care unit in cardiogenic shock. Although his presenting symptom was constipation, I noted severe pulmonary congestion, neck veins to the angle of the jaw, sky-high liver enzymes, severe hypotension, and oliguria. I poured all my energies into taking care of him overnight, barely sleeping a wink, and brooded over him for the next few days. Approximately 1 week later, he was ready for discharge, nice and pink, neck veins down, good blood pressure, and liver enzymes normalized. I proudly told him about his imminent departure and asked him how he was feeling. How disappointed and shocked I was when he responded “I dunno doc, I still have that CONSTIPATION.” From his point of view, I had done little for his real problem.

Modern medicine is able to work wonders. We can transplant weary hearts, implant devices that diagnose and effectively treat a host of complex rhythm disorders, fix major congenital heart defects by catheter procedures in utero, and maybe someday gene-surgically correct otherwise fatal gene mutations in embryos. But the value of this is limited if we fail to pay attention to the human side of our calling, to the social,

psychological, and contextual aspects of health and disease in the human beings we are caring for. Surely “caring for” involves more than just being available to perform noninvasive tests, corrective procedures, and device implants.

The *Canadian Journal of Cardiology* is launching a new series of articles about which I am very excited that addresses some of these issues. The series is called “Notes from Cardiology Clinic” and is written by a distinguished senior cardiologist, Dr David Waters. Dr Waters is a Canadian, one of whose dubious distinctions is that he recruited me to the Montreal Heart Institute (MHI) in 1987. In the late 1970s and 1980s, Dr Waters revolutionized our understanding and practice of acute coronary care in collaboration with his colleagues at the MHI, Pierre Thérout and Henry Mizgala. He was director of the MHI Research Center in the late 1980s and then moved on to direct the Division of Cardiology at the Hartford Hospital and University of Connecticut. Approximately 10 years later, he became the Chief of Cardiology at the San Francisco General Hospital and the University of California at San Francisco. Dr Waters has been a world leader in clinical research on atherosclerosis, the prevention and management of coronary artery disease, and the conceptualization and testing of new therapeutic approaches.

One of the wisest early moves I made as the Editor-in-Chief of the *Canadian Journal of Cardiology* was to invite Dr Waters to be an Associate Editor. In that position, he has provided wonderful skills as a judge of articles and a wealth of high-level connections in the world of cardiology. He provides detailed and helpful feedback to authors, particularly to junior authors whose manuscripts are being rejected. I have personally been deeply impressed by his caring advice, particularly to individuals who are clearly young investigators who would likely otherwise get short shrift from any other editor (sadly probably including myself).

In Notes from Cardiology Clinic, Dr Waters highlights experiences in his long and distinguished career that sensitize us to that other, critical, human side of medicine. The first

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article in that series appears in the present issue of the *Journal*.¹ In this article, Dr Waters deals with our responsibilities to patients when their personal interests potentially conflict with our perception of the requirements of honest professional conduct. Beyond any legal issues, we are always faced with a moral dilemma in such cases. Who has not had a patient who wanted them to provide a favourable report on their condition and colour it a bit so that they receive disability payments, obtain medical insurance compensation, avoid an awkward day in court, or be excused from disruptive jury duty? I guess we might all say that we would be meticulously honest, but when confronted by a sympathetic patient and medical issues that are not clearly black and white (i.e., the real world), the answers may be less clear cut.

I read the article in the present issue of the *Journal* with great interest and look forward to the subsequent articles in

the series. I hope our readers enjoy and learn from them as much as I did. At the very least, they should make all of us stop to think.

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Reference

1. Waters DD. Notes from cardiology clinic: when our responsibilities extend beyond the patient. *Can J Cardiol* 2019;35:1294-5.