Family Medicine Moments

July 11, 2024

Introduction: I have no words for the passing of our good friend and colleague Jim Ledwith. The words others have used about his commitment to students, the city's free clinics, those with substance use disorder and chronic pain, the Fitchburg residency, Learning Communities, MCSTAP (Massachusetts Consultation Service for the Treatment of Addiction and Pain), and more were saint, mensch, selfless, ...

I am going to let Jim's words speak for themselves. Below are two pieces he wrote for the FMM (formerly TMM). The first is a reflection sadly and ironically about Jim helping someone to die with dignity. Jim knew that a good family physician cares for a patient right to the end, transitioning from curing to helping and caring. The story is a reminder to us all that there is always care we can provide. The second is a treatise on how wonderful it is to be a family physician. That is how I will choose to remember Jim - a man who embodied the spirit of family medicine and he was able to capture it below. I am crying as I write this. He gave and gave and gave and in his last moments on this planet he even gave his organs per his wishes so that others would still benefit from his selflessness.

Jim - you will long be remembered. Long and well. We loved you and hope for all the best for your family.

This will be the last edition of FMM for the academic year. We will start up again in September. For this upcoming year - our 50th anniversary as a department - we would very much enjoy hearing from alumni with your stories over the last 50 years. Thank you.

A Tribute to a Family Physician

By Jim Ledwith

Title: Sadly Successful
Author: Jim Ledwith
Date: February 3, 2011

This week Jim Ledwith, the Residency Director of the Fitchburg Family Medicine program, shares with us a reflection that he recently wrote. He captures how successful patient-centered care can be, and yet how sad that success can be as well.

I feel sadly successful today. I stopped treating an illness, and cared for the patient as he had asked me to do.

My patient: a hard working technician who drove all over New England in his work. He had been lucky before we met. A small stroke essentially resolved. We met at his follow up visit to talk about risk factor reduction as he returned to work. That opened the door to learning more about his lifestyle. He was essentially alone in the world except for his business contacts and a few cousins that he saw on holidays. Years of abusive drinking had estranged him from his ex-wife and children for decades. He was content in his life though alone.

“Let’s talk. You’ve had one heart attack, and now a stroke. You‘ve been lucky enough to recover with no major disability. What do we do and who will I contact if something else happens?”

“If I can’t take care of myself, I don’t want to be here.” He had cousins but no proxy, and over a few more minutes of what-ifs, it was clear that if this independent man wouldn’t be able to get up and walk outdoors on his own, he wanted nothing else done to sustain his life. I was not to prolong a life of dependency. Proxy forms? He would think about it. That was June.

Fast forward eight months to another stroke. During my recent vacation the patient suffered a devastating stroke. He received excellent, aggressive treatment appropriate for his disease, but perhaps not for his condition. His vital functions were greatly improved when I rounded on Monday morning, but he was still paralyzed and still aphasic. We continued his successful IV therapy while evaluating the situation. It is clearly a bit late to confirm and document restricted care directives when the patient is aphasic. Would he change his mind now? Is the lack of a nod a “No”? Does turning

away indicate disagreement, frustration, depression, or separation from others to prepare for the end?

His cousins had a nice visit with him over the holidays. He had had another brush with critical illness and fully recovered after a ruptured AAA. He told his cousins he would think about signing those proxy forms but he never did it to anyone's knowledge. As he did with his doctor, he told his cousins that he didn't want to be "kept alive." Refusing a gastric tube, even refusing to eat, would be his way. If a stroke would take his independence, then it would take his life. It was the startling anticipation of our situation.

I had some very caring people who helped to sort out the situation. The ethics committee came together in less than 24 hours. It was not on paper, but he told me and he told his closest relatives. Additional IVs and gastric tubes will prolong what he saw as an agonizing existence. "It's okay to let him go."

In the interim, the IV therapy strengthened him and a new conversation was less one sided. He acknowledged his doctors and nurses. With nods and gestures he made it clear that he wanted us to stop all treatment. His cousins agreed, and his children, in an act of reconciliation, took part in affirming the decision. We coordinated terminal care in a nursing home. Today, less than a week after transfer, my patient's life ended peacefully. Sadness. Success.

Title: Thank God, I'm a Family Doctor
Author: Jim Ledwith
Date: November 17, 2016

After a week of shock and a long election cycle, folks seemed to turn in different directions to find a way forward. Jim Ledwith, former residency director of the Fitchburg Family Medicine Residency, offers us another place to turn. Our work is where we have always been grounded and always will be. He describes how his work helped remind him that our hope is our one on one relationships with our patients.

Thank God, I'm a Family Doctor (an old slogan on a button from an AAFP meeting years ago.)

I came to the office the morning after the elections tired, concerned, and uncertain. How will a revolution in Washington impact our practices? I was frustrated by system dysfunction – a backlog of messages left after an EMR shutdown the previous evening, inadequate staffing to support my work, an exhausted supply of influenza vaccine, lack of any clinical data for a patient two days out from a five day hospital stay for pneumonia, lack of coordination after a previous night's visit to the emergency department, and need for an urgent prior authorization – all part of the job of a family

doctor. Lunch came at 1:30 instead of noon, and I cranked through orders and notes as I gobbled down a sandwich. This doesn't happen every day but it is part of the work for every family doctor.

Exhaustion. Frustration. Topped by uncertainty about the system. It is easy to focus on the frustrations. At the end of the day comes time for reflection. It was a hard day and I wondered, did I accomplish anything?

Let's look back:

- I encouraged an obese middle-aged man on antipsychotic medications who has bordered upon diabetes for years and I congratulated him on a normal blood glucose and a steady 15 pound weight loss this year.

- I assured the readiness of a hypertensive woman for surgery that would correct her disabling carpal tunnel syndrome while redirecting her care for a cervical radiculopathy that she had assumed was part of the other condition.

- I treated the ongoing allergic reaction to hospital administered antibiotics that had not been addressed at discharge and coordinated home care to prevent a third hospitalization in as many months – also celebrating the support of her friend of 30 years who was named in the renewed health care proxy form.

- I struggled into the depths of my recall for motivational techniques for a frustrated man who wasn't ready to address his diabetes with medication or lifestyle changes.

- I retrieved ED notes for the man with suspected DVT and coordinated his anticoagulation while arranging a definitive test, deferring it for 2 more days due to his preferences and tasking my nurse to seek the report when it gets done.

- I balanced the risks of an opioid to manage the pain of spinal stenosis in a woman who is caring for the last of nine siblings who is dying from cancer, while supporting her in her anticipatory grief.

- I guided the school bus driver in managing the NSAID gastritis that developed as we treated the osteoarthritis in her right knee that ached with every application of the bus brakes. Then I assured her that I would call her husband in to better address the spinal pain that had prompted him to consider speeding up the end of his own life.

- I peeked in on the visit of a newborn infant who I delivered with a resident just a few weeks earlier.

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- I pulled in the support of a teammate to address the urgent dyspnea of a patient with COPD who had not managed to see us for follow up for 2 months after a hospital stay.

- I treated a woman who resolved that the heroin used 18 hours earlier would be her last. I administered her first dose of buprenorphine and she quickly celebrated a sense of renewed hope and normalcy as cravings abated and then we started focusing on “routine” prenatal care for her newly diagnosed pregnancy, looking forward to a safer pregnancy and healthier infant than she could have imagined just a week ago. I rushed the prior authorization request for her medication – incredulous that I needed special permission to do the right thing for an unborn child.

“I” did these things, not alone but with a team of colleagues and staff members who struggled with me to meet the needs of our community. I extend my thanks to each and my apologies for abruptness when urgency met frustration when our patients were in need. Family doctors do this stuff. Thank God we do. We look with new uncertainty about the shape and structure of our future practices, but we can expect that we will continue to be meeting the needs of one patient and one family at a time as we organize our systems to address the needs of the community.

Friends, I close every visit of students applying to our residencies with this sentiment and I share it with you: Our patients, our families, and our communities need you. Thank you for choosing to be a family physician.