

ing for every dollar in such prematurity costs avoided.

Rather than representing a good investment of increasingly scarce health care resources, Makena will force patients, physicians, and those responsible for financing care to make hard choices. K-V Pharmaceutical has announced a copayment-assistance program, but no program providing short-term financial assistance to some patients will mitigate the harm that this new cost will cause to publicly funded programs, including Medicaid, and the women who rely on them. Nor will it mitigate the cost to employers and individuals who purchase insurance coverage and therefore directly bear all increases in health care costs. This tremendous cost increase

and the likely decrease in access to an effective medicine are sizable unintended consequences of the FDA approval of 17OHP. They demand reconsideration and corrective action.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1102796) was published on March 16, 2011, at NEJM.org.

Editor's Note: On March 30, the FDA announced that it “does not intend to take enforcement action against pharmacies that compound hydroxyprogesterone caproate based on a valid prescription for an individually identified patient unless the compounded products are unsafe, of substandard quality, or are not being compounded in accordance with appropriate standards for compounding sterile products.” On April 1, K-V Pharmaceutical announced that it was reducing the list price of Makena to \$690 per

injection and would expand its patient assistance program. Both the House Committee on Energy and Commerce and the Federal Trade Commission are investigating the pricing of Makena.

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The Loneliness of Visiting

Ranjana Srivastava, F.R.A.C.P.

“The problem is the poor chap is lonely. If they sat with *him* a little more, they wouldn’t need to call *us* as much!” My harassed intern is venting her frustration with Mr. Wilson’s relatives. The 76-year-old man has languished in the hospital for the past 3 months, a resident of practically every major unit in turn. He was first admitted to Surgery for an emergency laparotomy, which revealed bowel cancer. From there, he went to Rehab for a short stint. But he developed pneumonia and was transferred to the Medicine unit, where he needed an isolation bay. When he became agitated, the night resident gave him haloperidol. But he became sedated and, unable to find his call bell or attract anyone’s attention through the

closed doors, he got up unassisted — and fell, fracturing his hip. Ortho took him to the operating theater, after which he returned to Rehab. Two weeks into Rehab, his abdominal wound dehiscd. So he is back in Medicine for antibiotics and wound care.

We, his medical team, sense another disaster lurking around the corner. His notes have spilled into another volume; his name tops the list of long-stayers, and although we try not to contaminate him with our sentiments, a certain pessimism clings to us. Just yesterday, I found myself telling the medical students, “Every day he spends here he is at risk for a new complication.” It was the most relevant teaching point I could come up with.

Mr. Wilson belongs to the di-

minishing category of people who have “never been to the hospital until this happened.” Now, he feels battered by his circumstances. He has no appetite. The wound is malodorous. His arms are bruised from regular IV changes. The repaired hip feels stiff. To the well-meaning psychiatrist he carefully explains the difference between being depressed and finding the situation depressing, though lately he seems even more withdrawn. He answers in affable monosyllables. Often he just listens passively, not bothering to protest or engage. His transformation from active citizen to dependent patient is complete.

Mrs. Wilson, though pleasant and concerned, is an old 85, troubled by an osteoporotic spine.

Her daughters used to drive her in and sit with their father, but the visits have gradually become shorter and fewer. They have full-time jobs and families.

"Why don't they come anymore?" I ask the intern.

"I don't know," she muses. "It's almost like they have stopped caring what happens."

What happens next in my life seems to have occurred almost by design: "I have bad news," an acquaintance phones to tell me. "Brad had a stroke — he's in the ICU."

I have known Brad since my student days. Alarmed, I rush in. He lies in intensive care, intubated

can hear me. His extubation is the first opportunity to assess recovery. To everyone's disappointment, he exhibits unilateral neglect and excessive agitation. Within a day, he is diagnosed with pneumonia. It is impossible to ascertain whether he is agitated owing to pain, pneumonia, or the stroke.

The fog in his head seems dense. Even without sedation, he can stay awake only for minutes. If you stand in front of him, his gaze might meet yours, but it takes the eye of faith to read recognition into it.

"Take my hand," I urge. Sometimes I imagine a weak squeeze

of medications, and we make small talk. I tell her Brad and I go back 20 years. "That's special, Brad!" she enthuses. He looks at her blankly and innocently. My heart sinks. It seems unkind to leave but painful to stay.

And so it is during repeated visits to Brad that I realize just how difficult and lonely visiting a patient can be. In fact, the sicker and needier the patient, the harder it is. Sitting with Brad, with neither conversation nor technology to distract me, I am forced to consider the vagaries of life. There we were, only 2 weeks ago, relishing lunch on a patch of green and watching my children bounce on the trampoline. For all I know, we may have had our last full conversation. As I take in his tired body, I fear what lies ahead for him. Will his pneumonia worsen? Will his hypertension abate? Will he be able to recall the countries he has traveled to and the books he has read? No doctor knows. No test can tell. To be in the powerhouse of medicine and yet be stumped by these questions is maddening. Brad's fate could be anyone's fate — it is an introduction to one's mortality, and it gives pause for thought.

And slowly, I see why it might be easier to just make phone calls from the safety of one's home than to be witness to a seemingly unending stream of medical misfortunes. Or why it might seem like a good idea to slow down the visits or find a dozen other things that take precedence over visiting someone in the hospital.

In response to my expectant eyes one day, Brad's doctor summarizes his progress. Her first five sentences are laden with medical jargon, which I follow silent-

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and senseless after undergoing emergency neurosurgery for a brain hemorrhage. His head is bandaged, and there are tubes everywhere. The ventilator displays reassuring numbers, but an intubated patient dependent on a machine to draw breath seems the epitome of vulnerability. His blood pressure is precariously high. A drain tube snakes out of his skull. A urinary catheter hangs off the other end of the bed. There are multiple IV lines, a nasogastric tube, bulky compression stockings on his legs, mittens on his hands. Even with his substantial build, Brad seems dwarfed by the surrounding paraphernalia.

Visiting on the days that follow, I edge my chair close to his bed. I say a few words, self-consciously wondering whether he

in return, but other times his hand falls limply to the side. The effort of turning in bed is too much. His face becomes red and flushed as he rests back, defeated.

An uncomfortable witness to his situation, I reach reflexively for my phone. But I had to turn it off, so I cannot go through my messages and pictures, which are months old and of no consequence but would make for an easy distraction. My newspaper is unwieldy in the small space. The precautionary gown and gloves makes it even more impractical to hold Brad's hand. A touch through powdery gloves feels slippery in practice and intent. I look up, but there is not even a muted television screen to stare at mindlessly. The nurse busies herself with the next round

ly until she halts. “I am sorry — are you a doctor?”

“Yes, but I am here as his friend.”

“OK, so you understand.” She relaxes and continues her summary.

In fact, I have many questions and even more worries, but with her feet already pointed toward the door, I feel like an intruder.

I would like to deny it, but in her, I see a reflection of myself and my colleagues, and it makes me feel ill at ease. I wonder if we become so accustomed to speaking in jargon that it becomes the

dialect of first choice. How little must patients and their relatives really understand of our attempts to communicate with them. How many cues are missed on an average ward round? Could the way we talk make relatives feel uncomfortable instead of involved?

My mind goes back to the Wilson family. Their reticence now seems somewhat easier to understand, their silence easier to sympathize with. I can’t remember the last time someone arranged to sit down with them, although many teams diligently flock past his bedside every day.

I am confident that our pessimism is matched by their lack of empowerment. I realize that their puzzling reaction to illness is not so much selfishness as self-insulation.

I am not quite sure yet how I will teach my young intern the difference, but I feel lighter for knowing it myself.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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