Manners, Morals, and Medical Care

How to be an Effective Physician

Barry Silverman
Saul Adler
Editors

Springer

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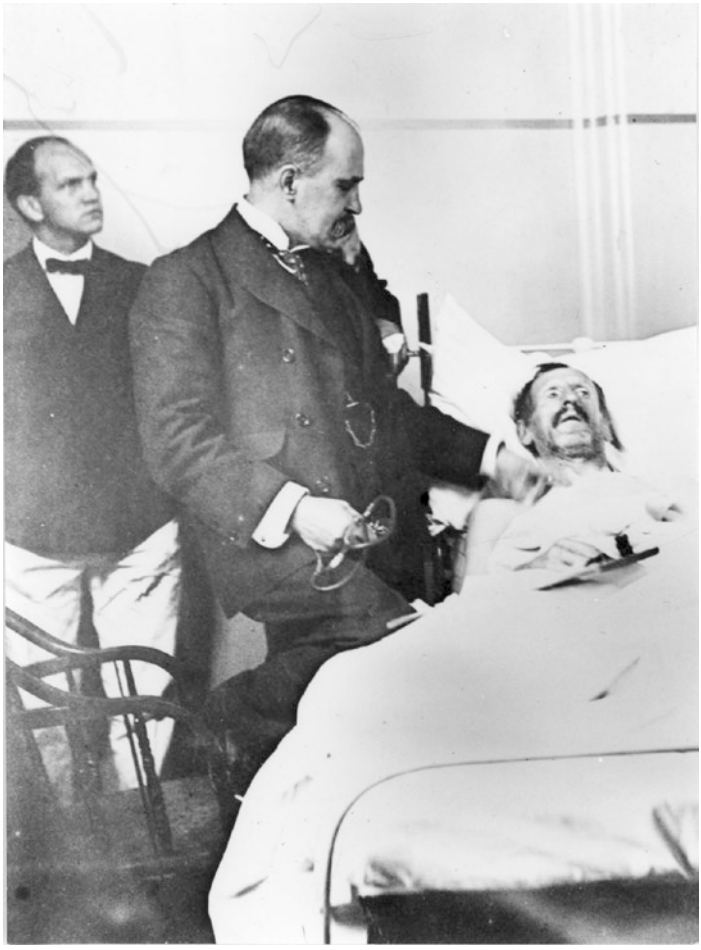

William Osler at a Patient's Bedside with Stethoscope in Hand

Barry Silverman • Saul Adler
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The Art of the practice of medicine is to be learned only by experience; 'tis not an inheritance; it cannot be revealed. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become an expert.

William Osler[1]

The more our time seems to force us into an inherently confused relationship of doctor and patient, the more firmly must we recall what a true physician is like.

Karl Jaspers[2]

[1] William O, Thayer WS, Osler the teacher. In: Silverman ME, Murray TJ, Bryan CS, editors. Osler and other papers, 1. The quotable Osler. Philadelphia: American College of Physicians; 2003.

[2] Jaspers K. Philosophy and the word. Regnery Publishing, Inc.; 1999.

To our patients. You gave us opportunities to practice and improve our medical skills and wisdom, all the while teaching us the wisdom and importance of improving our social and interpersonal skills.

Preface

When writing our first book, *Your Doctors' Manners Matter: Better Health Through Civility in the Doctor's Office and in the Hospital*, we designed the book to address patients' questions and concerns about appropriate medical care. When we shared the book with physicians who teach medical students the core curriculum in clinical medicine, they requested a text directed to medical and other healthcare professionals in training, believing such a book would be of value in the course work. This book, *Manners, Morals and Medical Care: How to be an Effective Physician*, covers important subjects in the medical school curriculum, including the elements of medical professionalism. We also explore in some detail several other subjects applicable to a wider audience, such as burnout, bias, sexism, and bullying.

While our goal is to improve our patients' health, we must never forget those who seek our care are our critical partners, at times quite literally putting their lives in our hands. Our patients must trust us to follow our recommendations. To earn that trust, we must behave in a way that shows respect for our patients' dignity. To that end, in many of the chapters we provide fictionalized true stories illustrating those qualities doctors and nurses must have to practice quality medical care. No matter how skilled or schooled, without those bedside manners necessary to exhibit compassion, empathy, and respect for a patient's dignity, no one can practice quality care.

We believe the reader will find the story telling entertaining in some cases and in all cases instructive. Many of the anecdotes can serve as discussion points in an academic set-

ting. Although names and places have been changed and dialogue paraphrased and recreated from memory, all are based on real events and many include personal interactions of the authors. These experiences enable us to present advice we have both received and developed after over 75 years of combined medical training and practice.

This is not a philosophy book, nor a synopsis of medical professionalism, nor an academic discussion of compassionate care. Rather our goal is to present a practical and interesting guide for healthcare professionals and the rationales supporting our recommendations

Manners, Morals and Medical Care: How to be an Effective Physician also includes brief bios of mentors and heroes who provide paradigms for healthcare practice. These doctors and nurses are examples to motivate, influence, and excite the reader as they complete their training and enter into practice. William Osler noted, "You enter a noble heritage, made so by no efforts of your own, but by the generations of men [and women] who have unselfishly sought to do the best they could for suffering mankind. Much has been done, much remains to do; a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

Atlanta, GA, USA — Barry Silverman
Atlanta, GA, USA — Saul Adler

Acknowledgments

The origins of this book trace back to a series of conversations between Dr. Barry Silverman and his late, older brother, Dr. Mark Silverman. Both men were directors of their respective cardiology departments in two major hospitals in Atlanta, Georgia. During frequent discussion over time they realized one of the major causes of patient dissatisfaction, patient failure to follow up, and unexpectedly poor outcomes arose because of a breakdown in physician–patient communication, often resulting from a lack of basic societal norms of civil behavior.

Dr. Mark Silverman, who died in 2008, encouraged his brother to put a book together for the general public advising the interested reader what they should expect from their doctor during an office or hospital visit.

Our colleagues who read the book were very complimentary, and many requested a similar book aimed at their medical students or residents describing what their patients expect in the way of good manners; not just bedside manners but civility in all the patient–professional interactions, how and why practicing civil behavior is important in patient care, and how to act in such a manner as to be perceived empathetic, highly motivated, and well educated.

This book is enlarged in scope to be useful to all medical professionals, and we hope you will find it of use to you, your colleagues, and your students.

Just as a symphony conductor receives most of the credit when all goes well, so the author of a book gets the most notice. However, just as a successful musical performance is a team effort, producing a book is also the result of a team working in concert. Our first reader for this book, Martha Silverman, com-

bined wisdom and experience with grace and humor. Unlike the authors, Martha did her work in a timely manner.

Hal Herd, M.D., and Felice Adler-Shohet, M.D., were invaluable resources for the parts on media and pediatrics. Gil Martin, M.D., served as an early reader and advocate for the book. His continued friendship, support, and encouragement throughout the project were invaluable. Drs. T. Jock Murray, Joe Stubbs, Sandra Fryhoffer, Cliff Cleaveland, Eugene Braunwald, and W. Bruce Fye offered clear-eyed and honest advice. Any omissions or errors are entirely due to the authors' editorial decisions.

Working with Springer has made this process as painless as possible. Melanie Zerah has been a delight to work with. Her patience, cooperation, experience, and insight were invaluable. K. Sheik Mohideen, working half a world away, managed to get the manuscript into an acceptable format. Finally, Kristin Rodgers, librarian at Ohio State University College of Medicine, provided a great deal of time researching references and offered invaluable resources.

Barry Silverman, MD
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About the Editors

Barry Silverman was born in Springfield, Ohio, in 1942. He attended Ohio State University where he received his BA and MD degrees in 1967. He completed his medical residency at Vanderbilt University Hospital in Nashville, TN, and his cardiology fellowship at the Johns Hopkins Hospital in Baltimore, MD. Dr. Silverman served 2 years in the heart disease and stroke control program of the USPHS. He was recruited by Emory to start a cardiology teaching program at Northside Hospital in Atlanta, GA. Dr. Silverman served full time in the Emory faculty until 1979 and continued as the director of the Northside Hospital's cardiology department and internal medicine education until 1999. He served as director of cardiology for the Kaiser Health Plan of Georgia for 15 years. Dr. Silverman is currently on the volunteer Emory teaching faculty at Grady Memorial Hospital. He was the editor of *Atlanta Medicine*, the journal of the Medical Association of Atlanta, for 25 years. He has written numerous scientific articles and book chapters and served in leadership roles with the Medical Association of Atlanta, American College of Physicians, American Heart Association, American College of Cardiology, and American Osler Society. Dr. Silverman has received awards from Northside Hospital, American College of Physicians, Medical Association of Georgia, and the American Heart Association. Dr. Silverman is married to Martha for 30 years and has two children Deborah Scott and Michael, a stepson John Auerbach, and three grandchildren.

Saul Adler, MD, MAPW, worked in a pediatric clinic during his military service and then received his neonatology fellowship training at the Boston Lying-in Hospital, now the Brigham and Women's Hospital, in Boston. While in the faculty at the University of South Florida Medical School, he established the first community-based, specialty-trained, nursing-staffed neonatology unit. Following the success of that experience, he was recruited to a community hospital in Atlanta where he founded and was the long-time director of a special-care nursery service that eventually grew to provide services for over 14,000 deliveries each year as well as the founding director of the pediatric intensive care unit at the Scottish Rite Children's Hospital. Dr. Adler lives in Atlanta with Rosalyn, his wife of over 50 years.

Biography of William Osler

Courtesy: Osler Library of the History of Medicine, McGill University

Title: William Osler at Work in the Blockley Mortuary
Location: Philadelphia General Hospital
Date: 1886 or 1889
Philadelphia Period (1884–1889)
Description: William Osler examining human organs at the Blockley Mortuary in Philadelphia.

William Osler
Revolutionized American Medicine as a Teacher, Leader, and Humanist

William Osler (WO) was the most famous and beloved physician of the late nineteenth and early twentieth century, and his influence continues to the present time. He was known for his devoted service, commitment to scientific advancement, and his rare qualities of humanity. It is seldom in the history of medicine that a man has won so completely and deservedly the admiration, love, and homage of the profession. He has created a lasting influence on what it means to be a doctor. WO was born in Bond Head, Ontario, Canada, on July 12, 1849. He was an athlete and scholar and completed his undergraduate work at Trinity College, Toronto, and medical school at McGill University School of Medicine. He joined the faculty at McGill and was active in clinical research publishing in physiology, pathology, and medicine. In 1878, at Montreal General Hospital, he began a practice of bedside teaching, a tradition that contrasted sharply with the didactic instruction at most medical schools. He was recruited as professor at the University of Pennsylvania, and then in 1889, left to assist in creating the new medical school in Baltimore, Johns Hopkins. At Hopkins, a new era of American medicine began following the German model with research laboratories and the English system of clinical clerks. WO wrote a textbook of medicine that had a profound influence on medical practice. At the height of his career and fame, he left Baltimore to before the Regius Professor of Medicine at Oxford University in England. Osler died in December 1919. His writings on humanity and the practice of medicine continue to influence us to the present.[1,2]

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[1] Obituary, *Boston Medical and Surgical Journal*, February 26, 1920. The *Boston Medical and Surgical Journal* as published by *The New England Journal of Medicine*. Downloaded from nejm.org by BARRY SILVERMAN on February 3, 2020. For personal use only. No other uses without permission. From the *NEJM* Archive. Copyright © 2010 Massachusetts Medical Society.

[2] Richard L. Golden William Osler at 150: An Overview of a Life. The Quotable Osler. ME Silverman, TJ Murray, CS Bryan. American College of Physicians Philadelphia 2003.

Excerpts from William Osler's "A Way of Life"

Fellow students—every man has a philosophy of life in thought, in word, or in deed, worked out in himself unconsciously. In possession of the very best, he may not know of its existence; with the very worst, he may pride himself as a paragon. As it grows with the growth, it cannot be taught to the young in formal lectures. Why then should I trouble you? Because I have a message that may be helpful. It is not philosophical, nor is it strictly moral or religious, yet in a way it is all three. It is the oldest and freshest, the simplest and the most useful.

"Life is a habit," a succession of actions that become more or less automatic. This great truth, which lies at the basis of all actions, muscular or psychic, is the keystone of the teaching of Aristotle, to whom the formation of habits was the basis of moral excellence.

Now the way of life that I preach is a habit to be acquired gradually by long and steady repetition. It is the practice of living for the day only, and for the day's work, Life in day-tight compartments…

To look back, except on rare occasions for stock-taking, is to risk the fate of Lot's wife. Many a man is handicapped in his course by a cursed combination of retro- and intro-spection, the mistakes of yesterday paralyzing the efforts of today, the worries of the past hugged to his destruction, and the worm Regret allowed to canker the very heart of his life. To die daily, after the manner of St. Paul, ensures the resurrection of a new man, who makes each day the epitome of a life.

The load of tomorrow, added to that of yesterday, carried today makes the strongest falter. To youth, we are told belongs the future, but the wretched tomorrow that so plagues some of us, has no certainty, except through today. Who can tell what a day may bring forth? Look heavenward, if you wish, but never to the horizon—that way danger lies. Truth is not there, happiness is not there, but the falsehoods, the frauds, the quackeries, the *ignes fatui* which have deceived each generation—all beckon from the horizon and lure the men not content to look for the truth and happiness that tumble out at their feet.

Waste of energy, mental distress, nervous worries dog the steps of the man who is anxious about the future. Shut close, then, the great fore and aft bulkheads, and prepare to cultivate the habit of a life of day-tight compartments. Do not be discouraged—like every other habit, the acquisition takes time, and the way is one you must find for yourselves.[3]

[3] William Osler, Osler's "A Way of Life" and other addresses, with commentary and annotations pp1-18. Shigeaki Hinohara and Hisae Niki. Duke University Press 2001.

Part I
The Importance of Being Professional

Chapter 1
Introduction

Barry Silverman and Saul Adler

DR. DELGADO'S BEDSIDE MANNER DID NOT INSTILL CONFIDENCE IN HIS PATIENTS.

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"The life of a sick person can be shortened not only by the acts, but by the words and manner of the physician. It is therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits…"

—Austin Flint, Sr., MD, 1883 [1]

Introduction

We have often heard patients complain about colleagues and other healthcare workers who are uncommunicative, arrogant, or sarcastic. They may say the doctor is disrespectful, or the office staff is unfriendly or uncooperative, even rude, abrupt, or just unhelpful. When patients finally get to see the doctor, they feel the time together is all too short. Perhaps a cell phone or nurse has interrupted the consultation. Maybe the doctor is habitually late for appointments and overbooked, or the patient feels they have to sit forever before they are ushered into the exam room, only to wait half-naked or in a flimsy paper gown.

These are just a few of the problems patients face in a doctor's office, and each represents a lack of professionalism, really a lack of caring. It gets worse. In the hospital, the patient might experience unfriendly admitting clerks, long waits, insolent or sharp-tongued nurses, and abrasive staff. Patients feel the staff lacks concern for their comforts. This is not unwarranted; they have to endure hard, uncomfortable chairs, long periods where they are left alone wondering if they have been forgotten, uncomfortable tests on hard, cold tables, and extreme thirst and hunger due to meals withheld prior to procedures. In the hospital, we have seen doctors round from the patient's doorway and go out of their way to avoid talking with families, even families of critically ill patients in the ICU. And yet, all this is nothing compared to the treatment patients receive at the hands of third-party insurers who seem to reject any semblance of customer service.

The healthcare industry is moving against the tide in our service-oriented economy. Hotels, restaurants, sports arenas,

and department stores recognize that courteous, friendly service and good manners make for a successful business, while medical establishments seem to cling to behavior that lies somewhere between uncivil and downright rude. While indifferent or rude behavior in healthcare may seem a trivial issue, a great deal of evidence, both anecdotal and in the medical literature, indicate that good manners and professional behavior at every level of healthcare result in better outcomes [2, 3].

Courtesy and Civility as a Corner Stone of Practice

During our combined 75 years of practice, most spent as the director of cardiology at a large community hospital (BDS) and director of a large neonatal intensive care unit and a separate pediatric intensive care unit (SMA), we have witnessed a gradual change in the professional behavior of doctors, nurses, and allied healthcare personnel and the harmful impact of unprofessional behavior on patient care. Before his untimely death in 2008, Dr. Silverman frequently discussed this issue with his older brother, Mark Silverman, a Professor of Medicine at Emory University School of Medicine and director of the Fuqua Heart Institute at Piedmont Hospital in Atlanta, Georgia. The brothers identified rude professional behavior as one of the most common problems they encountered in caring for their referred patients. They came to appreciate that poor medical outcomes are rarely based on a lack of knowledge and most certainly not a lack of caring, but often are a result of bad manners and occasionally outright boorish behavior. Such conduct in a social setting is annoying and leads to social avoidance of the offender. In a medical setting, it leads to mistakes, causes anxiety, and prolongs patient recovery.

Bad manners influence patient dissatisfaction with the medical care received and caregiver dissatisfaction with the work they are doing. While true malpractice is rare, we have

identified behavior problems on an almost daily basis that had the potential of causing a poor but preventable medical outcome—a tragedy for the patient and a potential lawsuit for the caregivers.

The medical profession is increasingly aware of professionalism as a critical element in the provision of quality care in our technological, impersonal, and entrepreneurial medical culture. Still there are some physicians who are unaware of the effect of their behavior on their patients, or just do not care if they are acting in an inappropriate way. Medical students now complete courses in medical professionalism, and we believed a short manual on good manners would be a welcome supplement to that course.

An instruction manual in manners for the profession might be received in a less than enthusiastic manner. We can imagine some young students' responses; possibly something like "Who are these guys anyway?" Then in quick succession and as the age gap increases, "Elitist. Outdated. Archaic." Or perhaps we will hear the remark our teenage children frequently threw at us: "It's different now," implying that the rules have changed.

Yet, books on manners exist for every other segment of society. It is not a matter of elitism but recognition that civility is important for the successful fulfillment of human interactions. There is a continuum of moral actions in daily life; existential matters are at one end and civility is at the other. Each is just as important in living a moral life.

The Hidden Curriculum

Students learn didactic studies in lectures, grand rounds, and seminars. Students learn behavior by example. The "hidden curriculum" [4–6] refers to medical education as more than simple transmission of knowledge and skills; it is also a socialization process. Wittingly or unwittingly, norms and values transmitted to future physicians often undermine the formal messages of the declared curriculum.

The importance of good behavior is stressed in courses on professionalism, but in most fields it is a given that 25-year-old women and men acquire these social graces well before they complete graduate school. Any further instruction in the specifics of proper professional behavior at the bedside is learned by example from senior residents, physicians, and professors. That is the tradition.

The tradition is not working. Although more and more of our medical school professors are first-rate scientists, many do not have extensive hands-on patient care experience. In the book *Learning to Heal: The Development of American Medical Education*, Kenneth Ludmerer describes how our medical schools have changed in the past 100 years [7]. Up until the last couple of decades, medical students received instruction from physicians with extensive clinical experience. Now many senior professors and other faculty responsible for teaching students bedside behavior have little direct patient care experience. Medical students learn how to talk with patients from other students, residents, and junior faculty. Their exposure to a senior, experienced clinician is usually brief and increasingly rare.

Methods of interacting with the patient and family that served well in the past are not working now, because of the momentous technological innovations in the past 30 years, which have changed the way doctors interact with patients. In the information, digital, computer age, physicians interact more with technology, digital data, and evidence-based algorithms than with patients, who are often ignored. Thoughtful bedside consultation and conversation is sometimes considered irrelevant, out of date, or just not possible or necessary to cure a patient in our present healthcare system.

Meeting Expectations

A good doctor or nurse must take the time to talk with their patients and establish a personal yet professional relationship. Your patient must trust you and allow you to know their concerns, experiences, and fears. Only in earning their trust

can you provide reassurances they will receive the best possible care you can deliver, or explain why results, procedures, or appointments have been delayed. An example of how communication can improve relationships is the detailed information some airlines now provide when a flight is delayed. Interestingly, this change occurred due to the anger and frustration travelers experienced concerning their trip and flight connections.

For patients to begin trusting you, they need you to listen and respond to their concerns. Patients want to be informed about all that concerns them: when will tests be done, who will consult and when, and what is the significance of everything that is occurring from a low-grade fever to an abnormal test or a normal one if the test is definitive. If the patient is in the hospital, they should be told when to expect the physician on rounds. The physician should be open to scheduling conferences with the family. Patients expect to learn the results of laboratory studies in a timely fashion, which is usually the same day in the hospital and the next day in the office. These are good manners, yes, but are also indicative of doctors and nurses who have taken on the responsibility of attending to their patient's health, comfort, and security.

Polite behavior in the medical office and the hospital not only improves the care patients receive. The behavior of the doctor and staff is a reflection of the moral underpinnings of their commitment to their patients and their profession. Judith Martin, the syndicated columnist who writes as Miss Manners—an authority on the rules of etiquette—authored an article for the "Proceedings of the American Philosophical Society" making just that point. She wrote, "Morality and etiquette form a single, albeit highly complex—and by no means conflict-free—system of rules for the governance of social conduct" [8].

Practicing Manners-Based Medicine

The term "evidence-based medicine" refers to the use of information obtained by the scientific method to determine the best medical treatment for a particular patient. When we

use the term manners-based medicine, we mean interpersonal behavior that expresses the moral principles underlying medicine. They are respect for human dignity, courtesy, acting to benefit the patient, causing no intentional harm, treating the patient with justice, and dedication to medical service. Manners-based medicine goes beyond doctor and patient interaction. Manners-based medicine can be applied to interactions between doctors and nurses, technicians, assistants, and administrators, each individual involved in any aspect of healthcare acting in a polite and well-mannered fashion that signals he or she recognizes the dignity of the other person.

We hope to show how the practice of good manners demonstrates concern for each other and marks the compassionate caregiver. Adopting the practice of everyday good manners in the medical office, clinic, and hospital can decrease costs by improving diagnostic accuracy through good listening techniques, foster trust by focusing attention on the patient, and improve patient follow-through by exhibiting compassion and empathy. Appropriate behavior among colleagues and toward patients will go a long way toward reducing the dissatisfaction many healthcare providers and patients struggle with on a daily basis.

In our experience, medical errors may arise when physicians and healthcare personnel are inconsiderate and communicate poorly. The Institute of Medicine estimates 100,000 deaths occur a year in hospitals because of medical errors: Some a result of careless, rude, or inconsiderate behavior [9]. According to a paper published in the *Journal of Health Care Finance*, a conservative estimate of the cost of lost years of quality life due to errors can be as high as $73.5 billion to $98 billion [10].

It has been our observation that some errors in management stem from careless, rude, or inconsiderate behavior. We believe some to many of similar errors can be reduced or eliminated with little cost to patient or doctor by practicing medicine in a polite and agreeable manner.

Even the most educated patient is unable to personally evaluate medical skills. But certain behavior characteristics indicate a healthcare worker who is capable of empathy and

caring, and one who takes pride in his or her profession. If your patient is knowledgeable about the behavior of the respectful physician, he or she will be able to identify you as one of the more effective doctors. If your patient offers a critique of your office or your professional demeanor, do not be defensive; rather welcome it. Be aware that your patient may be able to improve the behavior of medical professionals who do not yet understand how a conscientious display of civility, respect, and empathy are indispensable tools of their profession. Always listen carefully to what your patient has to say.

One of the best examples of a written guide to providing quality care comes from the Mayo Brothers in 1927. This guide remains the standard of care at the Mayo Clinic. It insures quality and encourages altruistic, and empathetic patient care.

Mayo Clinic Desk Book 1927

- A call from a patient takes precedence over personal engagements.
- Neglect of the patient means that you are in the wrong profession.
- A smile at the right time can often alleviate the sting of a bad prognosis.
- Taking personal interest in each patient is good for the patient, the Clinic, and yourself.
- Each patient is a private case, and that while the patients are here in large number, each must be treated as an individual with every courtesy possible. Do not get the "dispensary habit."
- That to each patient the present illness stands preeminent and while we may consider the ailment trivial or "neuro" the patient has spent time and money seeking relief and should have just and polite consideration.
- Knock on the door before entering a room not your own.
- Ordinary tones of conversation in the hall are often clearly audible in the rooms.

- Do not interrupt a consultant when he is examining a patient, more than is absolutely essential.
- No patient should leave dissatisfied.
- Ability to make friends of patients spells success in medicine.
- There is no trick to pleasing a patient who is easily pleased, but there is much satisfaction in pleasing one who is difficult to handle.
- Sheer bad manners denote without a doubt that a fundamental mistake has been made, that the Doctor has mistaken his vocation.
- Courtesy in this Clinic has proven a more valuable asset than self-constituted authority.*

*Used with permission from the Mayo Clinic

Published Courtesy Of Giula Nardelli Musee' D'historire De La Medicine-Paris

Hippocrates Refusing the Gift of Artaxerxes, the Persian King of Kings

Hippocrates – The Father of Medicine

Hippocrates was the most famous physician of the golden age of Greece. A time when Pericles governed Athens and promoted the arts and literature, Herodotus wrote his famous histories, Sophocles his classical plays, and Phidias carved immortal Greek beauty in marble statutes. Believed to be born on the island of Cos around 460 B.C.E. and to have lived into his 90s, he was a profound investigator, keen observer, and directed a preeminent and influential medical school. The many pupils gathered around him spread his teaching throughout the western world. The Hippocratic writing or the corpus are generally considered to come from his school on Cos or from the period of his lifetime, these include *On the Physician, Precepts, On Anatomy, On Honorable Conduct, On Diet, and The Aphorisms to name a few.* A popular Hippocratic aphorism is: *Life is short, and Art long; the crisis fleeting; experience perilous, and decision difficult* [11].

The Hippocratic essay "Decorum" advises physicians to visit patients frequently so that changes in their illness could be observed and addressed, and to pay attention to the environment of the sickroom…. Considerable advice is given regarding how physicians should present themselves in the sickroom. A cheerful demeanor was essential ("dourness is repulsive both to the healthy and to the sick"), as were actions that displayed an ability to calmly and assuredly deal with illness: "Bear in mind your manner of sitting, reserve… decisive utterance, brevity of speech, composure. The physician's own appearance also was significant…. Then he must be clean in person, well dressed, and anointed with sweet-smelling unguents…." There is a compelling passage in the Hippocratic Oath: "Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free." Because physicians make a public commitment to first seek their patients' interests and well-being, they are given access to the bodies, lives, and, at least traditionally, to the homes of patients [12].

Study Guide

1. Describe how respect for the patient impacts their medical care?
2. What are some expectations patients have from their doctors and nurses?
3. Imagine a dialogue between a doctor on first meeting a new patient.
4. Now imagine a medical student meeting a new patient. Are there any differences?

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Chapter 2
Medical Professionalism

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I observe the physician with the same diligence as he the disease.
—John Donne, 1573–1631 [1]

Medicine is an Art not a Trade, a calling not a business.
– William Osler [2].

Cranial nerves, bones of the hand, muscle origins, insertions and innervations, first-line treatments, SPACE bugs, Krebs cycle, oxidative phosphorylation—your medical training requires memorization and identification of all of it and much much more. You will memorize, understand complex facts and theories, know how to diagnose and treat diseases straightforward and complex, and how to comfort the ill.

Medical professionalism includes a mastery of all these scientific subjects, but also includes ethics, moral responsibility, lifelong education, stewardship of resources, and advancing the science. Yet all of it does not get to the core of the idea, for medical professionalism is a way of being. It is an expression of the idea that one's career is a process of becoming a better doctor, and echoes the expression the *practice* of medicine rather than the *doing* of medicine.

Medical professionalism is now a core competency taught through instruction and role modeling. Even before the white coat ceremony,[1] adopted by many medical schools in the preclinical phase of training, the process of becoming a medical professional starts with the reasons why one would choose medicine as a career.

Some are motivated to use their intellectual gifts to help others, some want to share in the status conferred by an honorable profession, some for economic reasons, and some to fulfill the dreams of others. With the white coat ceremony, the student who wants to be a medical professional now starts to become one, an aspirational goal that will lead to adopting certain moral principles, professional ethics, and professional responsibilities aligning with the community culture of like-minded physicians. When students enter clinical training, they will also observe and adopt the behavior of role models. This

[1] A ceremonial donning of the white coat and with it the metaphoric draping of the responsibilities and mindset of medical professionalism on medical students.

is called the hidden curriculum of medicine (see Chap. 1) [3]. In this chapter, we discuss the four foundational principles of biomedical ethics—patient autonomy, nonmaleficence, beneficence, and social justice [4]—and how they underpin the AMA Code of Medical Ethics [5], the code of conduct for human research as found in the Declaration of Helsinki [6], and the social contract between doctors and organized medicine with civil society expressed in the ABIM Charter on Medical Professionalism published simultaneously in *Lancet* and the *Annals of Internal Medicine* in 2002 [7].

Ideology of Medical Professionalism

Any profession is an "ideology [that] focuses more on the quality and social benefits of work than profitability. It is not a free market nor is it suited for control by the government or business." The late Arnold S. Relman, former editor of the *New England Journal of Medicine*, considered this ideology "the most important part of medical professionalism..." [8].

In 2002, *Lancet* and the *Annals of Internal Medicine* published a physician charter, a joint statement from the American College of Physicians-American Society of Internal Medicine and the European Federation of Internal Medicine in response to what the physician organizations called "changes in the health care delivery systems in countries throughout the industrialized world [that] threaten the values of professionalism." Agreeing with Dr. Relman's concept of medical professionalism, the Medical Professionalism Project stated, "that the conditions of medical practice are tempting physicians to abandon their commitment to the primacy of patient welfare" [7].

Three fundamental ethical principles underlie the ten core responsibilities of medical professionalism: the primacy of patient welfare, patient autonomy, and social justice. While technical skills and a knowledge base are critical components of excellent care, professionalism also imposes responsibilities: "those attitudes and behaviors that serve to maintain patient interest above physician interest," specifically knowl-

edge, competency, honesty, trust, confidentiality, propriety, quality, access, justice, and self-regulation [9].

The COVID-19 pandemic underscored the first principle of the Charter, that is, the primacy of patient welfare (beneficence). When our healthcare colleagues were faced with grueling hours and personal risk, they continued to provide care to all the patients who required it. They demonstrated courage despite the risks of close contact with a viral agent for which there was no specific treatment. This is an essential characteristic of the medical professional. Courageous physicians and nurses have continued in their duties through the ages despite personal risks. Examples include providing medical care during armed conflict, the influenza pandemic of 1918, the AIDS epidemic, Ebola virus outbreaks, and the COVID-19 pandemic. While infectious diseases are the most common reason where you may have to overcome anxiety about personal well-being, on other occasions you will be called upon to manage a mentally unstable and potentially violent patient, or treat a critically ill patient who is likely to die under your direct care, or you may be the only professional available to administer care in a medical crisis for which you did not train. In medicine, courage is not an abstract concept but a daily prospect. Doctors must overcome or accommodate to any fears concerning personal welfare as they tend to their patients.

The COVID-19 pandemic also underscored the idea of social justice as an underlying moral principle of the medical professional. The "fair distribution of health care resources" [10] became a very real issue concerning allocation of personnel, ICU beds, and ventilators.

The following stories demonstrate the importance of the second principle of medical professionalism, patient autonomy. As the charter states, physicians must be totally forthcoming with their patients so they can make informed healthcare decisions. You must explain why you are ordering tests, include how much their care will cost them if you know, explain plainly and without jargon what you are thinking and what your opinion is on their prognosis.

Mrs. M. is 85 years old. She recently lost her husband of 60 years, is in renal failure on dialysis, and almost legally blind due to macular degeneration. Her general practitioner referred her to a regional oncology center for clinical Stage III pancreatic cancer.

The consulting surgeon believes the tumor might be resectable, but the oncologist is doubtful, and the only way to know for sure is through surgical intervention. After a full and open discussion with her doctors about the discomfort associated with surgery and chemotherapy, she refuses treatment. Further, she no longer wishes to undergo dialysis. Is this a reasonable choice? What should the doctors do? What should her referring doctor do?

Although you may overlook it, there are two further areas you must share so your patient can give complete informed consent; that is your own physical and mental health, if pertinent.

Dr. K. is a 55-year-old physician who developed severe Reynaud's disease. He loved to operate, was exceptionally skillful and successful, and did not want to retire even though he had excellent disability insurance and a qualified medical disorder. The Reynaud's episodes had responded somewhat to medical therapy but could still occur occasionally. When they did, he was unable to operate. He arranged for an associate to be available when he was in the OR, discussed his medical condition with his partners and the surgical OR committee, and hospital administration. He was reluctant to inform his patients' feeling he had carefully considered their safety and had hospital approval. When questioned about his hesitancy to inform his patients, Dr. K. came to the realization that, among other reasons, he was afraid of being rejected because of his disease. The question we all must ask ourselves when we talk with a patient is this: are we withholding information relevant to the patient's medical decision-making.

While including medical professionalism in the core curriculum is relatively recent, the medical profession boasts a long history of describing how individual practitioners should treat patients in a beneficial and altruistic manner. Today

medical professionalism, while guided by the principles of medical ethics, defines the role of the physician in advancing both the profession and the professional qualities of the practitioner while delivering care with the patient's health the most important consideration. Among other qualities, medical professionalism means consideration of profit has no place in planning care for the individual patient. Moreover, the interests of the patient take first priority, even above the convenience of the treating physician.

Learning the medical curriculum is easy enough to understand. You have been mastering facts, figures, and procedures your entire academic career. However, you learn to interact with patients, colleagues, medical staff, and support staff by modeling your behavior after your mentors.

While certain professors may be held up as role models of impeccable manners and bedside behavior, often medical students' main contacts will be with other students, residents, and fellows. While most exercise professional behavior, the occasional clinician behaves in a way you will do well not to mimic. You must exercise caution when choosing role models. Copy your actions, both professional and quotidian, after respected physicians in your community, school, and among your peers, noting the results you achieve when you repeat their behaviors, and then integrating this experience with the knowledge you accumulate in your courses. In this manner, you will further your goal in becoming a medical professional. As Osler said, "Life is a Habit."

There will be times in your career when you feel it is too hard to maintain an even emotional keel while facing storms of anger or anxiety, or that an occasional joke can lighten a mood, or that respectful interchanges take too long or are unnecessary, or you can solve an interpersonal or transactional problem on the spot by force of your personality or position. Do not do this! We caution you to resist the impulse to deviate from best interpersonal practices. Problems in the hospital or clinic are best resolved in a private space, with a calm demeanor, and a helpful attitude. If you are concerned about a disagreement or hostility, the presence of a neutral third party is very helpful.

You may at first reject the idea that you have to emulate the behavior of experienced physicians, even the generation just before yours. It is not uncommon to go through an obstinacy phase and resent having to model something as personal as how to act. But there is no better way to learn how to be an effective, impactful, medical professional than to watch successful and respected doctors care for their patients.

Learning proper conduct on the ward or in the clinic is no different than learning how to aspirate a joint or do a spinal tap. First you learn what it is all about—the indications, the sterile procedure, the meaning of the results—then you watch a more expert colleague do one, then you do one yourself. Soon you will be the teacher—that is the "see one, do one, teach one" method of rapid learning in the clinical years.

This is also true concerning how to interact with a patient who has terminal cancer, or a nurse who is responsible for carrying out your orders, or a lab tech who is overwhelmed, or a consultant with whom you might have an honest difference of opinion. When you watch an experienced colleague deal with a difficult situation, you will learn the practical issues involved with performing personal interactions in an effective manner. The opposite is also true.

> Pediatric Nurse A and Dr. B, Assistant Professor of Pediatrics at University hospital, both single, had recently ended a very public affair in a contentious manner. Dr. B served as the attending for the house staff and students when one of the clinic inpatients, a 5 kg infant, grew *Candida albicans* from a blood culture. During teaching rounds, Dr. B asked the resident to write for a dose of 75 mg Amphotericin B to be delivered over 6 hours once/day, which the resident did. Upon mixing the IV solution, Nurse A noted it would take 10 vials of the reconstituted drug to achieve that dose. She questioned the resident's order during rounds, suspecting a decimal error. While the resident checked the dose on her computer, Dr. B overheard the question and abruptly asked, "Are you questioning my order?" This was followed by a demand that she give the dose as ordered, stating in a loud voice, "I'm the doctor here. Just follow my orders, please. This patient needs serious therapy." Nurse A knew she never had to use 10 vials to administer a pediatric dose, and by that time the resident had found the correct dose.

- Was Dr. B wrong to reprimand the nurse during rounds?
- Was nurse A wrong to question an order?
- What should the resident do now?
- How will this impact the students?
- Should the two co-workers have had a social relationship?

Any trainee/established professional power dynamic is asymmetric. What steps can be taken to de-escalate a situation when a potentially harmful confrontation arises?

The Hippocratic Oath, John Gregory, and Modern Concepts of the Doctor-Patient Relationship

A short history of the development of bioethical principles and medical professionalism provides context for the importance of adopting the core values and responsibilities of medical professionalism.

Before the advent of scientific medicine, exemplary bedside manners were often the only comfort a doctor could provide to patients. In the ancient Greek and Roman world, manners, aesthetics, and decorum were bound to ethical ideals. One of the earliest statements of an aesthetic and ethic text is the Hippocratic Oath attributed to Hippocrates of Cos (450–370 BCE) [11]. Among statements as to proper treatments for a limited number of diseases, the code also defines acceptable conduct. The physician is advised to be interested only in the benefit of the sick and to refrain from intentional injustice, mischief, and in particular sexual relations with patients.

Later Christian philosophers adopted the Hippocratic Oath and endorsed its message of the sanctity of human life. They added to it the Christian principle of charity.

In the early Renaissance, the concepts of ethics and aesthetics began to diverge. The role of behavior and manners changed from a way to achieve a just, moral goal to elevating one's personal status. The art of decorum was characterized

by egotism and social calculation. Good manners were a means to improve the individual's standing in the community, not to offer comfort to a suffering patient.

John Gregory, an eighteenth-century physician philosopher influenced by Francis Bacon and David Hume, practiced in the newly formed Royal Infirmary of Edinburgh. He was troubled by a common practice in the infirmary. The physicians who cared for the poor and sick would declare their patients incurable and then use ill-conceived experiments to treat them. Many of the patients survived despite the treatments, and this would create, among the doctors' wealthier patients, a reputation for the physician's success with the most critically ill. Gregory believed his fellow physicians were motivated more by a desire to increase their income than by dedication to patient welfare. He believed the physicians at the Infirmary exercised undue power over the poor and sick.

This led Gregory to deliver the first, modern, lectures in the English language directed at physician behavior and responsibilities. The series, published in 1772 as "Lectures on the Duties and Qualifications of a Physician," [12] exhorted his colleagues to adhere to the scientific methods of Francis Bacon and be open to evidence that might not conform to established dogma. He appealed to his colleagues to appreciate the pain, distress, and suffering of the sick. Gregory defined humanity as "that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which of consequence incites us in the most powerful manner to relieve…" He believed the exercise of sympathy was the "moral antidote of self-interest" [13]. Gregory's concept of manners was a means toward advancing the well-being of the patient. He believed appropriate dress and decorum would gain the patient's confidence, and at the time, in a hierarchical, male-dominated system the practice was likely effective. This central interest in the well-being of the patient places the "gentleness of manner" on the same level as humanity.

In 1803, Sir Thomas Percival, a student of John Gregory, in response to disputes at the Manchester Royal Infirmary between the physicians, surgeons, and apothecaries brought on by a typhus epidemic, was invited to publish his ideas on

proper physician conduct in the hospital and at the bedside. In this book "A Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons," [14] he coined the term medical ethics, detailing a code of intra-professional conduct as well as conduct toward patients, no matter their financial status. The two outstanding principles of *moral* ethics in Percival's code, beneficence and non-maleficence, continue to this day as two of the four moral principles of healthcare ethics, as we will discuss. Beneficence instructs patients and their physicians to enter into a relationship where the physician's primary goal is to improve the patient's health. Although Percival only addressed, in limited fashion, the use of the principle of beneficence as it applies to a physician's obligation to society at large, measures such as research, the employment of vaccines, and influencing governments to introduce or fund measures that improve public health can all be considered under beneficence. Percival also discussed at length methods to avoid causing deliberate harm, echoing the Hippocratic principle of *primum non nocere*. At the time, the ideas of social justice and patient autonomy were alien, medicine being an authoritarian, paternalistic profession and limited in the most part to those with means. Percival did encourage his colleagues to care for the poor who were sick but did not discuss social justice as a moral principle. In some cases, patient autonomy was discouraged, not becoming a consideration until the middle of the twentieth century. The two moral principles Percival wrote about, non-maleficence and beneficence, have been guiding principles since Hippocrates.

Prior to 1847, charlatans and apprenticeship style training marked US medicine. Many proclaiming to be doctors or healers operated as entrepreneurs, with a buyer beware ethic and no oversight. Medical schools did not require a high school education, there were no licensing or competency exams, and a student only had to pay tuition to receive a diploma. The quality of healthcare varied widely and had no standards. The public did not hold doctors in high esteem.

In 1847, the newly formed American Medical Association introduced the first ethical code for physicians in the USA [15]. The Code of Ethics of the AMA, borrowing from Percival's book, formed a contract between the profession, its patients, and the public, and dedicated AMA members to the needs of the sick [16]. The current AMA Code of Medical Ethics has undergone five major revisions, and as published in June 2016, is based on a set of nine principles of medical ethics followed by chapters expressing interpretations, opinions and explanations by the AMA Council on Ethical and Judicial Affairs [17]. The first of the AMA Principles states, "A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights." Thus continuing from antiquity the first standard of "conduct that defines the essentials of honorable behavior for the physician" [18].

A far-reaching reform of US medical education away from proprietary schools to university-affiliated graduate degree programs followed the publication of the "Flexner Report" in 1910 [19]. As a result of the reforms that followed, medical schools graduated highly educated professionals, and as medical science improved and increased the ability of doctors to care for the sick, the profession attracted the best and the brightest students.

In the mid-twentieth century, the discovery of antibiotics, insulin, modern anesthesia, antiseptic surgery, modern imaging techniques, and other extraordinary scientific advances further improved the public's perception of doctors as healers. Medicine ranked among the most admired and respected professions and doctors were viewed in the popular media as individuals working to improve the quality and length of lives.

Medical Bioethics and Moral Principles of Medical Practice

During the Nuremberg Trials following World War II, 23 Nazi physicians and bureaucrats were convicted of war crimes and crimes against humanity for their part in cruel and bizarre medical torture under the guise of human experimentation.

Drs. Leo Alexander and Andrew Conway Ivy of the AMA attended what is known as the Doctors' Trials and following the trial drafted a ten-point set of rules for human experimentation that became known as the Nuremberg Code. The memorandum, the first code of ethics specifically governing human research, served as guideposts for conducting human experimentation and included requirements for informed consent, an assessment of risks and benefits of the human experiments before proceeding, and the need for competent investigators to conduct the trials [20].

The 1964 Declaration of Helsinki expanded on the Nuremberg code by specifying several moral principles of bioethics applicable to human research, such as the primacy of patients' interests, autonomy, informed decision making, and special consideration for the safety of vulnerable individuals and groups, among others [21]. The World Medical Association declared the Declaration morally binding, and this was accepted by most national medical associations. Importantly, when the obligations of the Declaration set a higher standard than local or national laws, physicians were to be held to the higher standard.

In 1972, newspapers broke the tragic story of the Tuskegee Syphilis trial [22]. The study, its goal to define the course of untreated syphilis, violated almost every principle of biomedical research. Patients were not offered inform consent, when penicillin became available, its existence was not passed on to the research subjects nor was it made available to them. Any information not already known that could be gained by continuing the study was clearly outweighed by harm to the subjects. In 1974, in response to this tragedy, Congress commissioned an investigative study to determine what went wrong and how to prevent the errors from happening again. The Belmont Report, published in the federal register, established three basic moral principles of human research ethics: respect for persons, beneficence, including the admonition to do no harm, and social justice [23].

The three classes of codes might on the face of it appear redundant or at least confusing, but each serves a unique purpose and was created in response to unique circumstances.

Medicine is a science of particulars, each individual showing unique characteristics of often common maladies. Interests of the patient, doctor, family, institutions, and guarantors can conflict in various ways. While those conflicts may be quite specific, there are certain ethical principles that one can refer to for guidance. In the book, *Principles of Biomedical Ethics* first published in the same year as the Belmont Report, Beauchamp and Childress defined four principles of healthcare ethics that serve as pillars for support of the specifics of three different ethical codes [24]. (1) The "AMA Code of Medical Ethics," leaning heavily on Percival's 1803 Medical Ethics, attempted to establish standards of conduct of doctors in the mid-nineteenth century and establish a social contract between the newly formed doctors' organization and their patients. It has undergone multiple revisions and is meant for the guidance of physicians engaged in clinical care. (2) The World Medical Association's "Declaration of Helsinki" and in the USA, the "NIH Guiding Principles for Ethical Research" developed in response to Nazi atrocities and the Tuskegee Syphilis study. They are meant to establish strict rules for research involving human subjects.

Most recently, in response to "changes in the health care delivery systems in virtually all industrialized countries [that] threaten the very nature and values of medical professionalism" the ABIM Foundation, the ACP–ASIM Foundation, and the European Federation of Internal Medicine developed the (3) "Charter on Medical Professionalism". There are nine principles of medical ethics in the AMA Code, 22 basic principles for all biomedical research, and three fundamental moral values and ten responsibilities in delivering medical care as listed in the Physician Charter. However, each of the three documents rests on three or four of the fundamental "clusters" of moral principles defined by Beauchamp and Childress. The dedicated healthcare worker, without regard to which field one works in, would do well to keep these four principles in mind: (1) Respect for autonomy. (2) Nonmaleficence. (3) Principles of beneficence. (4) Principle of social justice.

Changing Attitudes About Physicians

Popular opinion reflects conditions as they are perceived and is never static. By the start of the twenty-first century, doctors had fallen from grace and landed far from their pedestals despite remarkable and innovative therapeutic advances. The portrayal of doctors on TV and in the movies documents this change and perhaps reveals at least one precipitating factor. The kind and empathetic twentieth-century doctors portrayed by Cary Grant's suave and gallant Dr. Noah Praetorius in the movie *People Will Talk* (1951), Dr. Sam Abelman, a man of unimpeachable integrity, played by Paul Muni in *The Last Angry Man* (1959), and Robert Young in the TV series *Dr. Marcus Welby* (1969–1976) displayed complete devotion to the welfare of their patients without regard to their own welfare.

The Gen X and Millennial doctors present a stark contrast. For example, in *The Resident* (2016), the young trainees are portrayed as altruistic combatants for justice and decency, saving lives despite constantly challenging authoritarian pomposity. Freddie Highmore's Millennial character in *The Good Doctor* (2015) is presented as without emotion, on the autistic spectrum, a savant able to save lives by force of his superior knowledge and observations, but requiring close mentoring. The majority of current TV medicos are seriously flawed human beings, including the sarcastic, rude, and unkempt Dr. Gregory House (2004–2012), a doctor who abuses prescription drugs, Dr. John Dorian of *Scrubs* (2001–2010), who has erotic daydreams while on patient rounds, and Doc Martin, of the eponymous English medical dramedy (2004–2017), an irascible but highly competent family practitioner, especially gruff with patients who question his authority. The odd contradiction is that in older movies, the best clinicians were also the best-mannered and most experienced doctors; now, the worst offenders of civil behavior are made out to be either the most effective physicians or elderly obstructions to competent medical care.

Over 60 years elapsed between *People Will Talk* and *The Resident*. The physician we see on the screen is no longer the preeminent, intelligent, self-assured healer with impeccable manners and a model of professional behavior. In our world, the doctor is often portrayed as abrasive, self-centered, arrogant, rude, and not capable of empathy. These portrayals are far from reality, but in some cases, the caricature reveals some small truth.

External Forces on Healthcare Delivery

The risk to professionalism as an ideology has escalated. With the introduction of managed healthcare and other novel health insurance plans**,** doctors and hospitals agreed to reimbursement plans in ways different from fee for service such as capitation, straight salary, and economic risk sharing, a system where doctors' compensation is partly dependent on money saved at the bedside and in the consultation room. As a result, the complexity of practicing ethical medicine has dramatically increased and at times keeping the patient's health and interests as the primary concern becomes difficult.

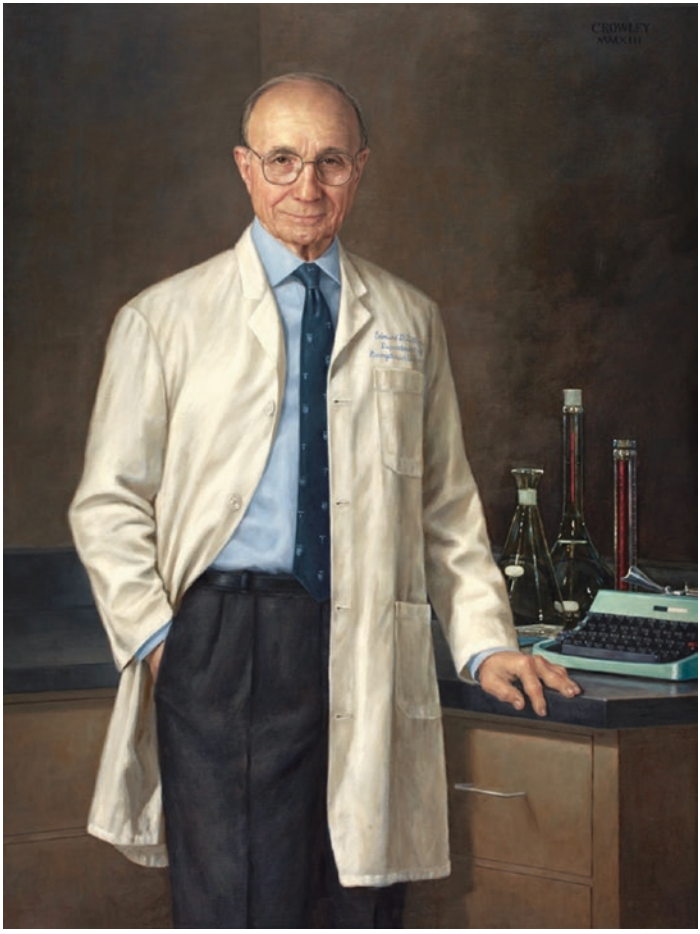
More and more hospitals buy up individual practices to form vertically integrated business models. This can create a clear conflict of interest. While ethical principles do not change, the threat to medical professionalism, that is assigning "a higher priority to doing useful and needed work than to economic reward" as Dr. Relman stated, is under attack. As an employed physician, the return on investment can become a priority for the organization if not for the doctor thereby creating an ethical tension. Not-for-profit hospitals are not immune to this problem; they must remain solvent in order to serve their community.

Similar problems became a great concern among medical leadership in the early 1990s. Some aspects of professionalism, so important to the social contract organized medicine

had with the public, were at risk. Doctors would appear to be, at the least, coerced by and at the worst corrupted by business concerns.

At about that same time residents were demanding more humane work hours and treatment, and with the influx of women into the profession, the issue of sexual harassment, long a problem between doctors and nurses, became more prevalent and needed to be forcefully addressed (see Chap. 6). With medical professionalism at stake, and the complexity inherent in practicing medicine in a more "competitive marketplace," a new statement of principles became a priority in medical schools. This led to the adoption, in many medical schools, of incorporating in the curriculum the concept of "becoming a medical professional." We will close with the following dramatized true story that spotlights the moral ambiguity that can arise when doctors and hospitals respond to the need for increased bed space.

> Dr. A and Dr. B. have worked together running an ICU for 10 years. Shortly after the ICU expanded from 10 beds to 20, Dr. A noticed more patients admitted directly from the ED for problems she thought were not life or limb threatening. Friendly with one of the ED physicians, at a social lunch she discovered Dr. B had asked the ED to admit all patients suffering from an asthma episode and gunshot trauma, no matter their level of stabilization. On further conversation, Dr. A. found that before agreeing to expand and modernize the ICU, the Hospital Administrator had threatened Dr. B. with termination if he did not keep the ICU beds at least 75% full.



Portrait by Jerry Crowley used with Permission

The Philosophy of Medicine

Edmund Pellegrino was a clinician, teacher, medical administrator, and a philosopher. He was one of the outstanding medical philosophers of the twentieth century. Dr. Pellegrino was born in Newark, New Jersey, and grew up in Brooklyn, New York. He was a graduate of St. John's University (1937) and New York University (1944). He served residencies in medicine at Bellevue Hospital, Goldwater Memorial Hospital, and Homer Folks Tuberculosis Hospital, following which he was a research fellow at NYU Medical Center in nephrology. He was chairman of the Department of Medicine at the University of Kentucky from 1959 to 1966, Dean of the School of Medicine at the State University of New York, Stony Brook, from 1966 to 1973, Chancellor for Health Affairs of the University of Tennessee from 1973 to 1975, President and Chairman of the Board of Directors at the Yale New Haven Medical Center from 1973 to 1978, President and Professor of Philosophy and Biology at the Catholic University of America in Washington, DC from 1978 to 1982. He was made the John Carroll Professor of Medicine and Medical Ethics and Director of the Kennedy Institute of Ethics in 1983. He remained at Georgetown University until his retirement. At that time, the center was renamed the Edmund D. Pellegrino Center for Clinical Bioethics in his honor. He and his wife, Clementine Coakley Pellegrino, were married for 68 years, until her death in May, 2012; he died in June 2013.

We would like to introduce you to some aspects of his philosophy to assist in your understanding of the moral and ethical basis for medicine. In his essay *Moral Choice, the Good of the Patient, and the Patient's Good*, Pellegrino makes the following statement [25]:

> *Acting for the good of the patient is the most ancient and universally acknowledged principle in medical ethics…It is the ultimate court of appeal for the morality of medical acts.*

However, what is meant by the patient's good can have many interpretations and you should carefully consider what this means when you care for your patients. Pellegrino comments:

> The good of the patient is a particular kind of good, that which pertains to a human person in a particular existential circumstance—being ill, and needing the help of others to be restored, or to cope with the assault of illness….A return to his or her definition of what constitutes a worthwhile way of life…..the physician promises to serve by his act of "profession" his promise to help with the special knowledge at his disposal. Inherent in the nature of the physician's offer to help is a tacit promise to use his knowledge and skill to advance the patient's good. This may be interpreted differently by the patient, the physician, or the family….. the physician is obligated to act for the good conceived by the patient and to support his goals…..the physician is obligated to promote four components of the patient's good: (1) *Ultimate good*—that which constitutes the patient's ultimate standard for his life's choices, that which has the highest meaning to him; (2)*Biomedical or techno-medical good*, that which results from the correct application of medical knowledge and skill; (3) *The patient's perception of his own good* at the particular time and circumstance of the clinical decision and how he prefers to advance his own life plan; (4) *The good of the patient as a human person,* capable of reasoned choices…..If we are not to violate the humanity of the patient in medical decisions, so long as the patient is competent, we must allow him to make his own choices. We cannot override those choices even if they run counter to what we think is good for the patient. To manipulate the patient's consent, to deceive or misinform him, even to do what we think is good, is to violate his good as a human being.

In an essay on the Internal Morality of Clinical Medicine [26], Pellegrino discusses the distinction between goods internal and external to a medical practice. He defines an internal good as "trying to achieve the standard of excellence definitive of that practice. External goods are those which do not contribute directly to attainment of the aims characteristic of a practice." His example is "Excellence in healing is, then, a good internal to that practice; making money is a good external to that practice." All members of the healthcare team who confront patients directly are also clinicians. Each is engaged in a special kind of human relationship with humans in distress…e.g. nursing, psychology, dentistry, allied health, etc."

Pellegrino states: "The medical good must be brought into proper relationship with the other levels of the patient's good. Otherwise, it may become harmful. What is medically

"good", if it violated higher levels of good, like the patient's good as he perceives that good." He is referring to the patient's personal preferences, choices, and values, and the kind of life he wants to live. He notes that these qualities and values are unique for each patient. Thus, medical good is not just about physiology but "the good peculiar to humans, like preservation of dignity of the human person, respect for his rationality as a creature who is an end in himself and not a mere means, whose value is inherent and not determined by wealth, education, position in life, etc. The patient is a fellow human with the physician to whom he is bound by solidarity and mutual respect."

Furthermore, Pellegrino writes:

> The highest level of good which must be served in the clinical encounter is the good of the patient as a spiritual being, i.e. as one who in his own way, acknowledges some end to life beyond material well-being. This may, or may not be expressed in religious terms. But, all, except the most absolute mechanistic materialists, acknowledge a realm of "spirit" however differently they may define it. This realm of spirit gives ultimate meaning to human lives.

Issues Addressed in This Chapter

- Medical professionalism: what it is?
- Why choose a medical career?
- History of medical ethics
- Role models
- Hidden curriculum
- Building on social skills
- Ideology of the medical profession
- Changing rules of the marketplace

Study Guide

1. How do you resolve conflicts on the ward? Consider the above pediatric case report and answer these questions.
   (a) Was Dr. B wrong to reprimand the nurse during rounds?
   (b) Was nurse A wrong to question an order?

(c) What should the resident do now?
(d) How will this impact the students?
(e) Should the two co-workers have had a social relationship?

2. Based on your personal observations, do you believe the public image of a physician in our culture has changed in the past 60 years? What about the role of the physician? Has that changed?
3. Consider the following questions concerning an economic conflict with your healthcare employer.

(a) Should Dr. A report the situation? If so, to whom?
(b) Was Dr. B. wrong to be compliant with administration's orders?
(c) Should Dr. B have refused the needed expansion?
(d) Should Dr. A transfer to the floor all questionable admissions shortly after admission? What are the implications of this?

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Chapter 3
Manners, Morals, and Medicine

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Manners are of more importance than laws. Upon them, in a great measure, the laws depend. The law touches us but here and there and now and then. Manners are what vex or soothe, corrupt or purify, exalt or debase, barbarize or refine us, by a constant, steady, uniform, insensible operation, like that of the air we breathe in. They give their whole form and color to our lives. According to their quality, they aid morals, they supply them, or they totally destroy them.

—Edmund Burke, 1729–1797

Manners Versus Etiquette

Patients bare their body voluntarily, prepared to suffer the poking and prodding into crevices and crannies where others have not ventured, or bravely suffer the insertion of sharp and painful instruments where none belong—and they pay for the experience. This is not a bizarre initiation rite, and the patient has not stumbled into a sadistic terrorist den. They are in their doctor's office.

One might suppose the medical staff, with whom they have entrusted the integrity of still-attached body parts, to exhibit sympathy and just a little deference for their bravery. Furthermore, it is not unreasonable to expect courtesy at least comparable to a bank teller, responsible only for money, or a barista at a coffee house, accountable for the foam on the latte. But often the medical staff in the office or in the hospital exhibits rude and churlish behavior, justifying a bad attitude with excuses: They are rushed, overbooked, dealing with emergencies, or underpaid by third parties. They are not responsible for their attitude—it is all a result of circumstances beyond control. Besides, the office manager might say if the patient has the temerity to complain, the doctor is the best in town and it does not really matter if he is rushed, or if she is frequently interrupted by phone calls, or if the computer screen gets more face time than the patient. What really matters is if the patient will get well.

Not so. Brusque and often rude behavior is not merely a question of incivility—good manners can make a difference in the quality of care a patient receives. We are all supposed to act in a civil and courteous manner, having been taught

lessons in manners and proper behavior since early childhood. However, if the number of books and articles complaining about and offering advice on interpersonal behavior is any indication, additional instruction is needed. The problem is modern society looks on lists of complex rules of behavior, etiquette, as a gate designed and erected by the privileged to exclude the unwanted and unschooled.[1]

The terms "manners" and "etiquette" are often used interchangeably, but they are different. Manners are a description of behavior in social situations. We learn our manners from our parents and teachers by example, instruction, and training, or we mimic the behavior of our friends and role models. Bad manners might reflect on childhood training, deliberate contrariness, or social mimicking.

Every society has rules defining the norms of social behavior. Rules of etiquette deal with table manners, dress codes for work and social events, and behavior in school, on the athletic fields, in the office, and for every personal decision about behavior, whether it affects others or not.

Rules of etiquette always seem to be under attack. Each new generation views the behavior of their elders as archaic and stuffy, and rules of behavior and those who advance them as unnecessary tools. In the Victorian era, complex rules of etiquette were used to separate social groups, advance snobbery, describe the way the best people were to behave, and distinguish the so-called well-bred from the common man. In a society where new wealth made possible by commerce and industrialization caused ancestral barriers to crumble, social rules of etiquette limited the elite class to the "well-bred." If you did not know the rules, you were not admitted into the game, but if you followed the rules, you could hide your background.

Up until the 1950s, rules of etiquette were often complex, restrictive, and unreasonable lists for everything from how to enter and leave an elevator, when a man should lift his hat, and who should be first through a doorway. The rules were designed to preserve the social status of those born to wealth

[1] The French word etiquette means ticket.

and position, protect the power of a male-dominated, and exclude those without the time, training, or desire to master their complexities. For many, the rules of etiquette were considered an elitist attempt to preserve a culture that no longer had a place in a modern egalitarian society and were counterproductive to social integration of the workplace.

Changing Social Conventions

No wonder the rules of etiquette were challenged, especially in the reactionary 60s and the two generations that followed. The baby boomers and to a lesser extent that transitional generation of depression and war babies before them (the Silent Generation) dispensed with the old rules and developed new codes of behavior wherever possible. They rebelled against authority in general and social conventions specifically, disdaining any authoritative edict on how to dress, act, or carry on relationships. If a particular behavior seemed appropriate and was not against the law, and sometimes even if it was, individuals or groups would do it.

In the past 50 years, we have seen an increase and an increasing tolerance of public incivility, rude, and inconsiderate behavior. There is a general perception that our society has lost its manners, and that short of inviting a court appearance, we take delight in flaunting behavioral norms or watching those who do. In a nationwide study entitled *Aggravating Circumstances: A Status Report on Rudeness in America* prepared for the Pew Charitable Trust by the nonprofit organization Public Agenda published in 2002, the majority of Americans surveyed believed rudeness is on the rise in our society and surprisingly, almost half admitted to being part of the problem. Seventy-nine percent believed lack of respect and courtesy is a serious national problem, and 73 percent believed Americans in the past treated one another with more respect [1].

Aggressive drivers, parents at youth sporting events, flagrant littering, cell phone users in public spaces, rude face-to-face attendants in retail stores, even ruder telephone customer service operators were all mentioned by respondents in the survey and are daily anonymous irri-

tants. It seems everyone has a story to tell about the shopper with the full basket in the quick checkout line, a healthy individual using a disabled parking spot, or the young, athletic office worker sitting in front of the granny standing in the bus aisle.

Examples of bad behavior are easy to find. Just consider celebrities like Jerry Springer, Howard Stern, Don Imus, and Maury Povich. All have made careers by celebrating rudeness. Uncivil behavior is in danger of becoming the norm. Our most prominent politicians deliberately exhibit rude, unseemly, and demeaning behaviors. They clearly feel this behavior is acceptable, but to many are offending and disrespectful.

Dependent on shock for entertainment, when the shocking is commonplace, these individuals create new frontiers of public incivility. Some "reality shows" reward rudeness. Rude behavior became such a problem in New York City that Mayor Giuliani, noted for his own brusque behavior and at times prickly demeanor, made public displays of civility an initiative of his second term, only to later change his behavior to mimic the President he admires.

We should not be surprised. Our elected representatives on both sides of the aisle have displayed incivility. Former Georgia Democratic Representative Cynthia McKinney struck a Capitol police officer when he failed to recognize her and stopped her at a checkpoint. Former Republican House Majority Leader Tom DeLay and Rep. David Obey (D-Wisconsin) got into a shoving match on the floor of the House of Representatives in 1997, and in 2006 Rep. Obey was seen on YouTube calling some of his fellow Democrats "idiot liberals." The 2016 Republican nomination process and to a lesser extent the 2020 Democratic nomination process, both "Reality shows" not unlike "Survivor," displayed examples of such behavior too numerous to list.

Is Civility Pertinent in Medicine?

If a list of rules of etiquette is outdated, civility is still pertinent. A voiced thank-you for a favor is not just a thank-you; it is an acknowledgment of a good deed or favor performed, and perhaps selfishly, an invitation to a repeat performance.

Listening and responding in a dialogue is not just a way of showing the person with whom we are engaged that we care about them and what they are saying; it is a critical tool for the effective exchange of ideas.

Unfortunately, the medical profession is not immune to the nihilism of manners in general society. In her book, *Miss Manners Rescues Civilization*, Judith Martin devotes four pages to the healthcare profession. She lists specific examples of rude behavior which include the following: systematically making patients wait for appointments, failure to treat patients with respect, skipping introductions, not asking for permission before touching a patient, not explaining procedures adequately, and discussing patients in hearing distance of non-medical personnel. She devotes an entire paragraph on the manner of dress and lack of neatness of the medical profession [2].

Evolution or Revolution

The behavior of the medical community has changed. Following World War II, large numbers of veterans from all social strata were determined to enter every profession. Many sought careers in medicine, and medical schools opened their doors to qualified applicants who might have previously been denied entrance due to class, ethnicity, or income. Initially barriers broke down slowly. Then, in the general upheaval of the 1960s and 1970s, with the confluence of the civil rights and anti-war movements and the push for female equality, the young, brash, bright, and self-confident men and women of the Boomer generation found many rules of behavior in medical culture either incomprehensible or irrational. This included a shirt and tie dress code, how long to wait for the often tardy professor before starting rounds, withholding opinions unless specifically asked, the formality of address, and standing at military attention at the bedside.

They simply refused to go along. Interns discarded uniforms of all white shirts, ties, white pants and shoes, and adopted informal dress. Scrub clothes became the new uniform of the day, not just for the OR but in hospital wards and

in the office. It was not just physicians but the nursing uniform of starched white dresses and nursing caps that disappeared, replaced by scrubs adorned with cartoons of animals, medical instruments, or abstract designs.

These symbolic changes reflected greater shifts in the profession itself. As the need for doctors increased, and in response to federal and state funding of care for the elderly and indigent (Medicare and Medicaid), medical school class size expanded, per capita grants to training programs were increased, and access to medical care improved.

Medicine had always attracted the intellectual and the empathetic, the problem solver who wanted to help a neighbor. Now the qualified student had the opportunity to enroll in medical school without regard to social class or background. With passage of the Hart-Celler Act in 1965, legislation of The Great Society that ameliorated the restrictive immigration laws of the 1920s, foreign medical graduates raised in alien cultures and unfamiliar with the formalities of American life entered practice, as did first-generation Americans raised in ethnic communities. This resulted in a melding of cultures and behavioral norms. This social fluidity further encouraged a relaxation of arbitrary rules of conduct that served no utilitarian purpose.

As medical school classes increased, so did the enrollment of women, who now make up over 50 percent of medical school students [3]. Like it or not, this has introduced gender politics into medicine. Deference in social mannerisms within the workplace, once considered courtly, is now looked upon as antiquated at best and demeaning by some. The traditional male/female, doctor/nurse hierarchical relationship has shifted as women and men assume roles in both categories. Nurses, once considered subservient to doctors, now provide first-responder care in emergencies and are included in decision-making at the bedside.

Transformation on the Medical Wards

Some practices considered symbolic of respectful behavior disappeared along with the superfluous. Attending physicians arrive on the floor in jeans and men with unruly facial hair.

The same scrub clothes worn in the operating room and the procedure room are worn in the office, often not covered by a white coat. It is interesting to note that in the nineteenth century, doctors wore suits on the wards (still a tradition at the Mayo Clinic) and in the office. White coats as a tradition began in Germany where laboratory medicine originated, and the physician came from the laboratory to the ward wearing his lab coat. Of course, the laboratory coat was to protect his clothes from chemistry lab stains. It is our impression that today's lab coats are just as likely to be stained with blood or other organic material and are frequently offensive to patients.

Doctors and nurses in the hospital, barely acquaintances, address each other on a first-name basis. Trainees and professors address each other informally. Patients are referred to as the gall bladder in room 350, the complainer in 234, or the gomer (a dehumanizing term for a debilitated, confused, often dying patient) in bed six. In the new culture, subtle mannerisms on rounds that demonstrate disrespect for the patient are all too common. Patients are frequently addressed by their first name, when their names are used at all. Teaching rounds are conducted without doctor introductions and trainees eat or drink coffee in front of the patients—we have seen a hungry resident take the toast off a confused patient's breakfast tray during teaching rounds.

Medical Students Learn Their Behaviors at the Bedside

Where does the young doctor-in-training learn manners and other social skills? Rarely in medical school courses, already challenged to incorporate into the curriculum an ever-enlarging body of medical science in a limited amount of time. Since all medical school students must have a college education and the vast majority have a degree, those accepted for admissions are expected to be caring and empathetic individuals who have already received extensive training and instruction in common courtesy and good manners. Twelve

years of elementary and high school followed by college classes in history, philosophy, and the humanities should render even the most contrary of individuals socially competent, and based on our experience with medical students, most are exceptionally well mannered, very caring, and empathetic when they enter medical school. However, some are changed by their experiences as they train and mature.

How does this happen? For the entering students—mostly young, inexperienced, and sheltered by family and the university—life's existential problems, if considered at all, have been studied at a distance rather than experienced. When they confront death or suffering in infants and children, or a young mother or father, or watch a family grieve as they themselves feel frustrated in their attempts to alter an inevitable course, the caregiver suffers personal emotional pain, depression, and feelings of inadequacy. The defensive response of some students may be to devalue the experience, or trivialize the dilemma with humor. The students risk a loss of perspective and empathy for the individuals involved. Young students, responsible for their patients' survival, exposed perhaps for the first time in their lives to the reality and absurdity of life, death, and disease, use dark, degrading humor as a temporary crutch. This can show up as inappropriate behavior and sometimes shape lifelong attitudes.

Learning from Mentors

A great deal of medical education and almost all postgraduate medical instruction is mentored training. The student or newly minted doctor learns not only diagnosis, treatment, procedures, and policies from his mentors, but also social skills. Young doctors learn professional manners at the bedside from senior residents in an unstructured manner and with little or no feedback from the senior physicians or patients. The senior attending physicians or professors serve as role models. But today's professors are often laboratory scientists and not experienced clinicians. They may also lack

the interpersonal skills required to handle difficult situations. Patient interactions are mostly limited to highly structured and formalized rounds that rarely mimic the true environment in the hospital or the office. Student contact with most patients is brief and episodic with no opportunity to observe the impact of bedside behavior on the patient or family.

When it comes to manners, medical students and residents seem to suffer from arrested development, and if students are supposed to learn professional behavior by example, then the system is doomed. In 1994, the *Journal of the American Medical Association* published a report "Disputes between Medical Supervisors and Trainees," citing several studies documenting misconduct and mistreatment of trainees by their supervisors and suggesting abuse and mistreatment of all kinds from a variety of sources—residents, nurses, medical students, and patients [4]. The perception is, when abuse arises, the victims suffer as a result of having less authority than the victimizers. In one study, abuse ranged from threats of academic punishment, trivial duties assigned to punish the student, verbal abuse, belittlement, humiliation, and even threats of physical harm. Sixty-three percent of trainees reported being belittled or humiliated by more senior colleagues and over half of female trainees reported having been sexually harassed at least once, with about half the incidents arising in medical school and half during residency. The manners students learn are the manners they observe.

It Is All About Respect

Boorish behavior by medical professionals is not just about generational attitudes. Consider Dr. Jesse James, a superbly trained urologist, a graduate of an Ivy League college and medical school, and the recipient of training at outstanding residency programs. Dr. James is known on the surgical wards for his abrupt demeanor and often disruptive behavior. He is condescending at best and very often rude to the nurses caring for his hospitalized patients. He seems to especially enjoy berating the nurses at his patients' bedsides. Dr. James mis-

takenly believes his behavior ensures the best and most meticulous care for his patients.

However, because nurses do not enjoy caring for his patients, when nursing assignments are made, his patients are assigned to the nurse with the least seniority or whoever draws the short straw. Nurses avoid him. When he rounds on his patients, the nurses make themselves scarce. Dr. James jeopardizes patient care with his outwardly rude behavior and the nurses compound the problem with passive-aggressive avoidance.

Dr. James is not likely to endear himself to those around him. If communication is poor among the healthcare team, even the most skillful physician will have difficulty achieving the desired results. His behavior and the effect on his colleagues negatively affect the health of his patients.

Dr. James's behavior reflects ignorance in social skills. He suffers from a lack of training in bedside manners. Unfortunately, his patients and colleagues must suffer as well. As we have pointed out, most medical schools have paid little to no attention to training students in courtesy and manners or building skills in social behavior in the core curriculum. The assumption is that the desire to do good necessarily leads to proper behavior. This assumption is as common in medicine as it is in everyday affairs. As Judith Martin writes, the error is "that from personal virtue, acceptable social behavior will follow effortlessly. All you need is a good heart, and the rest will take care of itself" [5].

Not so. We have noted a remarkable change and a lack of consensus in what is considered acceptable behavior. While we do not object to the trend toward an easing of formality, the corresponding decrease in civility, from the trivial omission of a title of address to the critical display of disrespect inherent in any public confrontation, has affected the quality of patient care.

Informality does not have to be tied to rude behavior. Along with relaxed standards of personal dress and the move away from plush office design with which we have no complaint and even welcome, we have seen a laxness in neat appearance and personal hygiene. We have observed some

offices, hospital rooms, and corridors in serious need of a cleanup crew. An open shirt collar looks so much nicer when connected to a cleaned and pressed shirt. Perhaps with the exception of a long weekend of in-hospital call, facial hair can be neatly groomed, and long tresses washed and combed.

Despite the loosening of formality in greetings between peers and colleagues, it is still not proper for doctors and nurses to address patients more than three times their age by first names upon initial meetings, or ever without permission. These may seem like inconsequential concerns, but they illustrate the bigger issue: the dignity of the patient and the need to address patients with empathy and politeness. Ignore those qualities and there can be no hope for open communication, and it is open communication that is critical to the doctor's improved understanding of the patient's complaint.

The profession of medicine no longer commands the respect it did 50 years ago; today doctors must *demonstrate* respect for each other and their patients to promote communication and mutual trust. That respect is no longer a given based on professional status. Without this, patients will not open up and recount the critical facts necessary for a diagnosis, be willing to submit to required testing, or even undergo the necessary treatment to recover. Civility builds trust and provides a basis for professional behavior that encourages positive, beneficial human interaction.

Modern medical care is all about teamwork. Individual members of the team must support and respect each other. Saving a life is like flying to the moon; it takes a lot of individuals each working in concert with the other. When physicians, office, or hospital employees are rude or disrespectful, they will be avoided and their patients will suffer.

Do Good Manners Need Guidelines?

Isn't it enough for the doctor to be pure of heart and want to do the right thing? Even in everyday personal exchanges, without guidelines for best behavior, we would not know what to expect when approaching another, and have no way to

measure rude behavior. Taking offense if poorly treated would be considered inappropriate because there would be no rules as to what constitutes poor treatment or fair treatment. Anarchy of manners would follow, and any behavior would be acceptable up to the point where the law is broken.

Imagine how this might work in a medical clinic. The internist decides his patients should sit naked in the exam room, reasoning that it will save time and the patient can dress when the visit is over. The surgeon calls his patients at home after 10 p.m. to tell them the biopsy was a malignant tumor. The psychiatrist schedules all his patients at 9 a.m. and the afternoon patients at 2 p.m. If he has a no-show, he can call a patient from his waiting room to fill in the empty slot, and he can be sure he is never waiting for a late arriving patient. Sure, the patient with the noon and 5 p.m. slot will wait 3 hours, but the psychiatrist will maintain a full schedule.

Of course, these examples are ridiculous (but are, in fact, actual examples), but so is a lunch-stained lab coat or not explaining to a patient why they need certain tests or medications. We expect a certain amount of privacy, neatness, and order in the doctors' offices. Although there are no laws addressing office management [6], there cannot be any argument about "clothing the naked" being both moral behavior and good manners, and alleviating anxiety a mark of the compassionate person.

Rules of behavior do change and are reflective of society, but moral principles such as consideration, respect, and tolerance do not. Rapid changes in medical science affects our system of delivering medical care; technology revolutionizes how we communicate both in the medical community and in general society. Acceptable behavior, once thought as established as arithmetic, now seems to need redefinition with every election cycle, but quality medical care based on good manners reflects unchanging moral principles. The heavy responsibility of caring for our fellows when they are at their most vulnerable is also a privilege and an honor. If this is kept uppermost in your mind when you are about to enter a hospital room or an exam room, you will be well on your way to achieving the goal of becoming a medical professional.

Photo Courtesy the Estate of Yousaf Karsh

Helen Taussig M.D.
Groundbreaking Pioneer

The story of Helen Taussig is about overcoming childhood hardships, systemic societal and institutional prejudices, bias, bigotry, and unoriginal thinking. She was a remarkably determined individual who used brilliance, tenacity, patience, and determination to achieve her goals. She was dogged but not intransigent and worked almost tirelessly to solve problems and care for patients. As with every great advancement, it was a team effort that for Helen came together in a very serendipitous way.

Helen Brooke Taussig (HT) was born on May 24, 1898, in Cambridge, Massachusetts, and was the youngest of four children. She has described herself as from a "direct line of teachers." Her father, Frank William Taussig, was a well-known Harvard economist and the first chairman of the United States Tariff Commission. Her mother, Edith Guild Taussig, studied natural sciences and zoology and was one of the first graduates of Radcliffe College. In childhood, she suffered recurrent ear infections which left her with permanent hearing impairment and was infected with debilitating tuberculous, a disease which killed her mother when HT was only 11 years old. She was dyslexic with considerable difficulty with reading, but her compassionate and caring father worked tirelessly to increase her competence and self-assurance in reading. Writing about HT's life, Gerri Lynn Goodman credits her father's compassion, determination, and investment of time as the qualities she acquired and modeled in her own work habits[2].

HT entered Radcliffe College but was not happy there possibly feeling the pressure of being referred to as Frank's daughter, and after several years transferred to University of California in Berkeley to complete her degree. She was interested in medicine but Harvard was not admitting women, and on the advice of her father she applied to the School of Public

[2] Goodman, Gerri Lynn. A Gentle Heart: the life of Helen Taussig. Yale University Press 1983

Health. There the Dean told her, "Well, we have decided that everyone should have 2 years of medicine and then we will permit women to study but we will not admit them as candidates for degrees." Her response was "who is going to be such a fool as to spend 4 years and not receive a degree." The Dean's response was; that is the point. The result of this hostility was that HT enrolled in Boston University medical school in 1922. After 2 years, Alexander Begg, the Dean of the Medical School and a mentor, advised her to transfer to Johns Hopkins in Baltimore where he felt there was an exceptional faulty and, most importantly, women were being admitted on an equal basis with men. In Baltimore, she excelled as a student, was elected to Alpha Omega Alpha, and graduated in 1927.

She continued at Johns Hopkins as an intern and cardiac fellow until Edward Parks tapped her to run the pediatric cardiac clinic in 1930. Dr. Parks, who assumed the directorship of Pediatrics in 1927, was a critical champion of Dr. Taussig throughout out her career. He was once asked to recommend someone who was not a woman or a Jew for an academic position and his response was, he would never recommend anyone for an institution that would not take women or Jews as they had made so many important contributions to his department.

The primary heart disease of American children at this time was rheumatic fever and these patients filled her clinic. She had no interest in congenital heart disease, but Dr. Park let her know this was part of her responsibility in running the children's heart clinic. Children with congenital heart disease were often sick, difficult to manage, and physicians who did not readily refer patients to a woman were happy to send her these ill, complicated patients. In HT's meticulous, thorough, organized assessment of her patients, she began to understand the anatomical anomalies and their physiologic consequences. In one disorder, referred to as the blue baby syndrome, a combination of defects including pulmonary valvular stenosis, ventricular septal defect, overriding aorta and right ventricular hypertrophy resulted in inadequate pul-

monary blood flow. Taussig noted that children whose ductus arteriosus remained open after birth had a better survival and less symptoms. The ductus arteriosus is a vascular connection between the pulmonary artery and the aorta. It is necessary before birth for the blood from the mother's placenta, healthy, oxygenated blood which enters the baby's right heart and crosses to the baby's circulation through the ductus. After birth as the baby's lungs expand, the ductus closes in most children spontaneously. If it does not close in healthy children, it is an internal shunt that overworks and exhausts the heart[3].

One of the first surgeries ever done on the cardiovascular system was the closure of a persistent ductus arteriosus by Robert Gross in 1938. Dr. Taussig approached Gross and asked if, since he could ligate a ductus could he create one. Too dangerous, too difficult not interested was the response. In 1941, Alford Blalock came to Johns Hopkins from Vanderbilt to be chief of surgery. He had ligated a ductus arteriosus and studied hemorrhagic and traumatic shock with surgical approaches including transplanting the subclavian artery into the pulmonary artery. Taussig approached him with her idea about creating an aortic to pulmonary artery connection. Dr. Blalock had brought with him to Hopkins, a very special man, Vivien Thomas. Thomas, an African American was trained by Blalock to be a lab assistant. A man of great ability, skill, and intelligence, Blalock officially titled him a janitor, not a lab assistant, and although he had great respect for his judgment and skills, he treated him like a servant. This emotional, complex story of American medicine is portrayed in the movie *Something the Lord Made*[4].

Thomas felt the subclavian shunt he had developed in Nashville to treat shock might be the best approach for this

[3] Engle MA. Dr. Helen Brooke Taussig: Living Legend in Cardiology. Profiles in Cardiology edited J Willis Hurst, C Richard Conti, W Bruce Fye Foundation for the Advances in Medicine and Science, Inc Mahwah, NJ 2003

[4] Something the Lord Made. https://www.imdb.com/title/tt0386792/

surgery. They created a dog model of the congenital defect and studied hundreds of dogs before their first operation on a child. On November 29, 1944, Blalock operated on the first child with Helen Taussig in the OR observing and Vivien Thomas leaning over Blalock's shoulder advising and conferring with the surgeon during the procedure. This was a truly remarkable advance by an incredible team led by a woman working with a brilliant bigoted, chauvinist, southern surgeon, and an African American who could not afford to go to college.

I studied under Dr. Taussig when I was training at Johns Hopkins in 1971. She was a tall, lanky woman with a large, radiant smile, so gracious, and her bedside manner was flawless. I would ask the patients, who were from all over the world, how they came to be Dr. Taussig's patient. They told me they were very sick and their parents had read about Dr. Taussig and wrote her letters asking if they could come to Hopkins to be treated. She answered their letters and told them when to come to Baltimore. They had been returning once a year ever since. They were truly devoted to her. She was a great clinician and even though she was nearly deaf at this time, she described every clinical detail and physical sign each patient exhibited. She was awesome, and I admit I was in awe.

Helen Taussig went on to many other achievements which included an authoritative textbook on congenital heart disease, the standard for decades, training several generations of America's pediatric cardiologists, advocating for prevention of death from lightening strikes, and helping save many Americans from the thalidomide disaster in pregnant women. She received numerous awards and was recognized by many societies, universities, and countries. The Time Magazine featured her face on its cover.

Issues Addressed in This Chapter

- Moral principles do not change.
- Courteous behavior communicates the principles of medical ethics.

- Good manners encourage good communication.
- Good manners are about respect.
- Every society has rules of social behavior.
- Behavior in the medical office has changed.
- Change in the doctor-patient relationship.

Study Guide

1. Have you seen or experienced abusive behavior from an attending or supervising physician? If so, describe the experience.
2. List three ways the case study with Dr. James jeopardized patient care.
3. What is your definition of empathy?

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Chapter 4
Compassion and Communication in Caring for Patients

Barry Silverman and Saul Adler

"Of course I'm listening to your expression of spiritual suffering. Don't you see me making eye contact, striking an open posture, leaning towards you and nodding empathetically?"

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> *The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head.*
>
> William Osler, 1849–1919

People take cues from the institutions around them. The emergency department of a major hospital in the southeast has 25,000 square feet of spotless, shining, tiled and glass-walled cubicles. Every hallway displays the sign "Courtesy & Respect." Yet patients are left waiting for hours before being seen, and other patients wait for what must seem like forever to be admitted to as yet unassigned rooms. Meanwhile their anxious families mark time in the waiting area, unaware of the fate of their family members or friends.

Maybe the hospital is understaffed or overcrowded, but it takes just a few seconds for the nurse or ward clerk to visit and reassure the patient they have not been forgotten, or to keep those anxiously waiting informed of their family member's progress. Why should the hospital or doctor's office behave differently from a restaurant where diners are warned if they have to wait for a table or are notified if their meal is delayed?

We expect common courtesy and good manners in business dealings. There is no good reason for your patient to settle for less in their medical care. Doctors and nurses work with patients at a most vulnerable period in their lives—during an illness—when listening attentively and encouraging questions is critical to the ability to provide good care. Yet not a day passes when a patient, family member, nurse, therapist, or physician does not take offense or feel bruised by the callous, inattentive, or disagreeable behavior of a colleague or coworker.

Civility and Respect Improve Patient Care

A compassionate caregiver treats patients with respect. Organized medicine recognizes the importance of respect for human rights and patient dignity in providing care. The first of the AMA "Principles of Ethics" states physicians must respect human dignity and rights. The four commonly held principles of bioethics acknowledge the human dignity in every person and the requirement that each must be treated with and is entitled to respect.

You want to be the doctor who provides good medical care and has compassion for patients. If your actions in the patient encounter do not demonstrate respect, your patient might wonder about your commitment to his or her health. In the absence of compassion, your patient might view your opinion as to diagnosis and treatment as suspect, even self-serving, and will probably not heed any instructions or even return to your office for follow-up.

Of course not every disagreeable encounter with a doctor or nurse is an indication of depravity, just as not every individual display of good manners is an indication of a person's essential morality. Ruthless dictators and sociopathic financial manipulators may display impeccable manners. But what is the patient to think if, when you enter the room, you do not state your name and your role, or when the nurse or technician who wakes your patient to change the bed linen does not murmur an apology?

Attention to good manners is particularly important in the hospital and medical office. Here many barriers of social convention are altered: unilateral nakedness, conversations about ailments, and intrusive questioning are all banned in civil company, yet these are critical to the medical encounter. With these barriers voluntarily dispensed with, the importance for you and your staff to act in accordance with other conventions of compassionate behavior—uninterrupted listening, solicitous attention to physical comfort, agreeable demeanor, and pleasant surroundings—cannot be overstated. A patient gets the impression of a doctor's capability, not from the physician's medical expertise—few patients have the training to make that evaluation—but rather from the doctor's concern for the patient as a human being. That concern is conveyed through manners, a willingness to consider the patient's feelings, preferences, and views, and an ability to communicate.

Rules of Etiquette

The famous Johns Hopkins physician, Philip Tumulty, addressed the issue of communicating with patients in his 1970 address to third-year medical students:

> Actually, what many patients miss and resent today is the inability to communicate with their physician in a meaningful manner. Patients have questions they want answered, fears requiring dissipation, misunderstandings that need clarification and abysmal ignorance about themselves that demands enlightenment. Today, many patients with serious health problems leave their physician's offices with less comprehension of what is wrong and what they must do to get well than the average customer understands about his car when he drives it out of his repair shop. And if the patient feels deprived of adequate communication with his physician, family members are totally devoid of it. No wonder the resentment [1].

How well the patient is treated in the medical office or in the hospital is not just a matter of attitude. It is a moral and ethical concern. Professor Cheshire Calhoun of Arizona State University, writing in the journal *Philosophy and Public Affairs*, includes civility as a moral virtue whose function is to communicate basic moral attitudes. Professor Calhoun makes the point that the importance of civility is in the "display of respect, tolerance, and considerateness…" [2] Judith Martin, in her book *Miss Manners Rescues Civilization*, describes manners as an "indispensable partner of morality," and that in order to avoid being offensive, we must treat each other with respect [3].

Rude and uncivil behavior, the opposite of what it means to be a medical professional, is often either ignored or given a pass. This leads to an escalation of misbehavior and a tolerance to tactlessness. Take for example Frank Johnson, a conscientious physician who always goes the extra mile for his patients. In addition to serving on numerous hospital committees, he also serves as a lay preacher in his church. One morning he was overheard criticizing the nursing supervisor, Susan Butler, who was responsible for the area where his patient had been admitted. Miss Butler is an experienced and respected nurse, highly skilled and capable, and known for her ability to defuse difficult situations. Apparently, Dr. Johnson's patient had not been weighed despite orders to do so. In view and within hearing of others, the doctor lost no opportunity to inform Nurse Butler of his poor opinion of the care his patient received, and then he moved on to a general critique of her crew. They did not raise their voices, but his

words and demeanor clearly indicated his displeasure. She nodded and apologized and tried to appease him with an explanation. After a few minutes, he walked off the floor, frowning and shaking his head. After the incident, Nurse Butler was asked about Dr. Johnson's behavior.

> "Rude? Dr. Johnson? No. He was unhappy because he thought the nurses had ignored his order to weigh his patient. But his patient refused to be weighed. I told him it wasn't the nurse's fault."
> "Did he apologize?"
> "What for? He was worried about his patient. That's how he gets."

The story was related to a committee studying ways to improve professional relations, a committee on which Dr. Johnson serves. No names were revealed, but after the meeting Dr. Johnson approached the committee chair, a close friend of his, and asked if the story was about him. Told it was, he looked abashed.

> "I didn't realize I behaved like that," he said. "I should have apologized."

This story illustrates the crux of the problem. Uncivil and often rude physician behavior in the professional setting is often accepted, tolerated, and excused. The perpetrator is never called out. The doctor who believes aggressive behavior is an effective management tool is not made aware of the effect of the behavior on colleagues and is surprised and insulted when feelings are hurt and blame is assigned.

Your patient expects excellent medical care, you expect your colleagues to treat your patient in a respectful fashion, and the nurses and allied healthcare personnel expect every member of the team to be respectful and supportive. When all involved in the healthcare team are familiar with the manners expected of them, incidents of misunderstanding and hurt feelings are reduced, and perceptions of rude and uncaring behavior are minimized or even eliminated.

It is not likely that enforcing rules of etiquette, often nonutilitarian, will encourage the virtues of compassion and respect, or stimulate intellectual curiosity. Dress codes do not make an effective staff; although a sloppy dress can result in perceptions of inferior care. Formal address does not equate with empathy; although an artificial familiarity can offend.

Polite behavior is not a complete indicator of a physician's ability; although, as we have argued, it is one of the most visible ways you can assess a physician's respect for his patients.

We recognize that most bad behavior in the medical setting arises, not out of callousness, or meanness or expected personal gain, but rather results from one of two circumstances. Either the individual exhibiting poor manners is unaware of appropriate behavior in any given situation, or emotions have run high and guidelines on how to handle a difficult interaction are lacking. Behavior one person perceives as rude another might consider appropriate to the situation.

When unsatisfactory interactions between doctors and patients and between medical professionals lead to increased tension and hurt feelings, the resulting stress requires a great deal more effort to resolve than simply improving communication. These conflicts are best avoided. A shared knowledge of what constitutes civility in interactions and common expectations of behavior can reduce conflicts and improve communication and mutual understanding. Commonly held conventions of behavior among medical professionals and between caregivers and patients will go a long way toward eliminating offensive behavior arising out of unmet expectations.

Rules governing civil behavior serve to place everyone on an equal footing by knowing what to expect from each other. Judith Martin believes the "objection to 'rules' of behavior is not that we wish not to be civil, rather each of us would prefer to decide which courtesies we wish to observe and which we don't."

Educating Your Patients About What to Expect

To be fair, medical institutions do take steps to educate patients on what to expect from their encounter. Hospitals and physician offices usually provide some information concerning billing details and how to resolve billing issues. Pediatric and obstetrical offices counsel young families on office hours and physician availability. On admission to the

hospital, a representative counsels patients and families on the rules of the hospital ward, hands out pamphlets on procedures, and explains visiting hours, parking, and paying the bill.

On close examination, however, this is all information given for the convenience and benefit of the caregiver and not for the patient. Patients are not given information on who has access to their room, when testing will be done, how to voice preferences as to when not to be disturbed, or how to be addressed. Patient rights, if mentioned at all, are limited to a pamphlet and a plaque on the wall, and the patient is expected to conform to the medical establishment's idea of how to act rather than the medical personnel conforming to the needs of the patient and their family.

Common courtesy requires anyone having contact with the patient to introduce themselves and state their role. The hospital or medical office environment is no different in this regard than any other place of commerce. Adult patients should always be addressed by their family name. Neat grooming expresses an air of respect. The patient should always be informed of any planned tests, their purpose, and when and how they will be notified of the results. In the hospital, the patient should be informed who is responsible for their care, what tests and treatments they will be receiving and when they are scheduled, when to expect the results and who will be responsible for providing them, if there will be discomfort, what pills they are receiving and why, as well as side effects and expected benefits.

When rounding, inform your patients and their family of the approximate time you will be on their ward. You must introduce everyone on rounds and any students must have the patient's permission to be present. Patients have a right to object to rounds attended by staff unfamiliar to them. Housekeeping, dietary, and laboratory personnel should knock and ask for permission before entering the room, and they should not interrupt the physician rounding on the patient.

There are times, it seems, as if hospitalized patients have less knowledge about their rights than prison inmates.

Communication with Your Colleagues

A disconnect can sometimes occur in the behavior colleagues expect from each other. This can cause miscommunication and contribute to medical errors. We understand some of your colleagues would rather make up their own rules and extend some considerations but not others. But we believe, as does Miss Manners, that this creates an anarchy of manners. As Miss Manners writes, "People making up their own rules and deciding which courtesies they want to observe, and which they don't, is exactly the problem that has been identified as incivility and lack of consideration" [4]. The doctor can be clueless as to why the nurses feel he or she is condescending, sexist, rude, or demeaning. The nurses in turn may not agree with a doctor's evaluation of them as disrespectful, bossy, or uninterested in their patient.

The physician is expected to observe at least the basic elements of civility. Absent a set of rules to govern interactions, the result can spell disaster for the patient, create an unfortunate impression about the doctor, result in large personnel turnover, and leave doctor and nurse or technician feeling abused or demeaned, angry, and insulted.

In a manners-based medical office, the staff will communicate by their words and deeds that their patients are individuals deserving respect, consideration, and tolerance. Manners-based medicine in the clinic, office, and hospital improves relations among colleagues and with other healthcare workers, and we hope creates a better impression of the profession as a whole.

No other profession, with the possible exceptions of the clergy and moral philosophers, is more concerned with the concept of human dignity and worth than the medical profession. It is by our actions in our everyday lives, showing good manners, that we demonstrate the intrinsic value each of us acknowledges in the other simply by being a healthcare worker. The healthcare profession presents to the practitioner special situations that elevate the usefulness of good manners from a guide for acting in an agreeable manner in everyday situations, to providing guidelines for the efficiency and coordination necessary to save life and limb in potentially chaotic situations.

Photo of Dr. Mona courtesy of Mike Naddeo photography

Mona Hanna-Attisha, MD MPH FAAF
Fearless Advocate for the Health Rights of Children

In 2011, Flint, Michigan was a city in decline, the population was shrinking, the majority of residents were African-American, and the city was heavily in debt. The Governor appointed an emergency manager to oversee the city and cut costs. This resulted in a catastrophic recommendation to change the city water supply from Detroit River to a less costly alternative of the Flint River. The river water was corrosive and residents complained the water was foul and smelly. Still, the city insisted the water was safe. On 24 September 2015, at Flint's Hurley Medical Center, Dr. Hanna-Attisha revealed that Flint children's blood lead levels doubled after the water was switched from the Detroit River Great Lakes to the Flint River. She conducted her research after talking to a high-school friend, a drinking water expert and former engineer with the Environmental Protection Agency Office of Ground Water and Drinking Water. She was informed that the water was not being treated with proper corrosion control ingredients and that Marc Edwards, a water engineer and professor from Virginia Tech and his team of Flint Water Study researchers, reported high levels of lead in Flint residents' homes. Using hospital electronic medical records as data for her study, she confirmed Flint's water contamination and its effect on the health of Flint's children. At a risk to her career, Hanna-Attisha disclosed her findings and demanded action at the 24 September 2015 press conference before her research could be scientifically peer reviewed, a decision she made to protect the city's children from further harm. Her findings were later published in the *American Journal of Public Health* and confirmed in a *Morbidity and Mortality Weekly Report* published by the Centers for Disease control not Center and Prevention.

Dr. Hanna-Attisha's research was initially ridiculed by the State of Michigan, when a Michigan Department of Environmental Quality spokesperson accused her of being an "unfortunate researcher" "splicing and dicing numbers" whose behavior was causing "near hysteria." About 10 days later, after *The Detroit Free Press* published its own findings,

consistent with Dr. Hanna-Attisha's findings, and after she engaged in one-on-one conversations with Michigan's chief medical officer, the State backed down and concurred with her findings. Later, at the press conference in which the State acknowledged the lead in water crisis, Department of Environmental Quality office officials apologized to her. In his State of the State address, the Governor publicly thanked Hanna-Attisha and Edwards for sounding the alarm about the Flint water crisis [5].

Since helping to uncover the Flint water crisis, Dr. Hanna-Attisha has spearheaded recovery efforts and served as a national public health advocate. As founder and director of the Pediatric Public Health Initiative, she has built a model program to mitigate the impact of the crisis, promote the health and development of Flint children, and share best practices with similarly impacted communities. Her 2018 widely acclaimed book, *What the Eyes Don't See: A Story of Crisis, Resistance, and Hope in an American City*, continues to motivate and inspire readers to courageously stand up for justice and build a better world for all our children.

Dr. Hanna-Attisha is founder and director of the Michigan State University and Hurley Children's Hospital Pediatric Public Health Initiative, an innovative and model public health program in Flint, Michigan. A pediatrician, scientist, activist, and author, Dr. Hanna-Attisha has testified twice before the United States Congress, was awarded the Freedom of Expression Courage Award by PEN America, and named one of *Time* magazine's 100 Most Influential People in the World for her role in uncovering the Flint Water Crisis and leading recovery efforts. An immigrant, Mona was born in Sheffield, England, to Iraqi scientists and dissidents who fled during Saddam Hussein's regime. She grew up in Royal Oak, Michigan, received her bachelor's and Master of Public Health degrees from the University of Michigan and her medical degree from Michigan State University College of Human Medicine (Dr. Mona Hanna-Attisha, Personal Communication).

Issues Addressed in This Chapter

- Characteristics of the Medical Professional: "Compassion and respect for human dignity and rights": the first of the AMA "Principles of Ethics."
- Civility demonstrates morality.
- Rude and uncivil behavior results in poor medical care.
- Patient expectations: civility, caring, listening, answering.

Study Guide

1. How does Dr. Johnson's behavior on the ward disrupt patient care?
2. How would you have acted if you came on the floor and found out your patient had not been weighed as you had ordered.
3. What are examples of "rules" to be followed in the office and ward to respect the patient and improve patient care?
4. What would you say to a colleague who is unconvinced that good manners are important manners is pleural to good patient care?
5. Address the argument that manners prolong the pleural the workday.
6. The principle of beneficence is not specifically mentioned in the Physician Charter of Professionalism discussed in Chap. 2. What is it and why would it not be specifically mentioned?

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Chapter 5
How to Act as an Effective Physician

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The physician's job is to treat and care for people; not to just diagnose and cure an illness.
Cary Grant as Dr. Praetorius in the movie "People Will Talk," 1951

The Essence of Bedside Manners

How should a doctor act? What constitutes good bedside manners? Professor Sarah Buss writing in the academic journal *Ethics* about the moral significance of manners in society, notes "one of the primary objectives of…manners are to encourage us to make ourselves *agreeable*" [1] [emphasis in original]. Professor Buss describes the most important lessons in manners as "the lessons in how to avoid being discourteous, impolite, rude, inconsiderate, offensive, insulting." To flout these lessons, she writes, is not only impolite, it is immoral. Judith Martin, writing about manners and etiquette, and Professor Buss, addressing manners and morality, agree that people have a basic moral obligation to make themselves agreeable to others.

Medical professionalism includes as one of the core values a moral commitment to medical service based on "the potential for health and illness and on a resultant respect for the inestimable value of human life and health" [2]. What Professor Buss calls the "subtle language of good manners" is how you or the members of your staff say, "I respect you." If a show of respect requires good manners, then good manners is not just a core value of good medical care, it is what your patient should expect from you and the people with whom you work.

You must make it clear that you respect your patient, not only to satisfy the ethical principle, but because when patients are treated with respect, they will believe you care about their welfare. Just as importantly, as Professor Buss points out in the same article, "[I]t is precisely because treating people with courtesy is a direct way of acknowledging their dignity that treating them rudely can undermine their belief in their own intrinsic worth." The practice of good manners is espe-

cially important in medical care where the requirements of a thorough evaluation, if not conducted in an agreeable manner, can be stressful and embarrassing. There are few situations where a person is more vulnerable to assaults on their self-esteem than sitting in the doctor's waiting room ill, or in pain, or fearful of survival. Manners are a way of one person communicating to another the message: I believe you have dignity, and I respect that. As Dr. Buss states, "When we treat one another politely, we are expressing respect for one another…We are, in effect, saying: I respect you, I acknowledge your dignity."

Improving Communication

Good manners are not only a form of communication; good manners foster good communication. Implicit in an office appointment or a hospital consultation is an unstated request to work with the patient to improve a condition or maintain good health. A display of good bedside manners signals you are willing to cooperate in that venture and will devote time to fulfill it. Anything less than this response would limit the effectiveness of your consultation. Without it, your patients might not be entirely forthcoming about the history of their illness, or might view the recommended treatments with suspicion and very likely will not follow the treatment plan. Most of the time you spend in conversation allows your patients to tell the story of their illness. Many patients are anxious and uncomfortable. The bedside or office manner is critical in establishing the relationship necessary for them to open up freely and discuss their problem. If your patient is intimidated, or feels in any way disrespected, or you are rushed, frequently interrupted, fiddle with the computer or phone, communication necessary for a diagnosis will be lacking.

This means bedside manners include a smile, eye contact, complete attention to the patient, body language that conveys you want to be there, and are very interested in your patients and their concerns—really their fears and anxieties.

Their story, the medical history, will be incomplete if you do not convey a real interest. It is why you are there. Forget everything else when you step to the bedside; just focus on your patient.

All medical students have heard the aphorism dating from horse and buggy days, "When you hear hoof beats, don't look for zebras." It is also true you have to guard against missing the uncommon disease. Your patient's ability to tell their story completely without many interruptions, voice their concerns, and state what they believe is their problem is critical to the delivery of good medical care. An attentive doctor engaged with the patient is more likely to provide the information needed to make the correct diagnosis and provide good follow-up care. This is illustrated by the following true story. (All names and places are fictional and the dialogue is recreated.)

Mary Carruth first came to see Dr. Cooper after an 8-month history of heart failure. Her first cardiologist had diagnosed her as having hypertrophic cardiomyopathy, an unusual disease, but not a rare one, occurring in as many as 1/500 people in the general population. Some people with this condition, a thickening of the heart muscle, have no symptoms, and for some it can cause fatigue and shortness of breath. This disease is the most common cause of sudden death in young athletes in the USA.

The disorder usually stabilizes for decades on the medication her first cardiologist recommended. Mary (she preferred her given name) had been followed closely and taken her medication, but despite this, her weakness and heart failure progressed. She was hospitalized six times at a large, state-of-the-art facility.

Her cardiologist, a well-trained, technologically competent physician, attributed her worsening condition to failure to follow his recommendations.

When Mary visited the cardiologist's office, she usually saw the physician's assistant. Despite asking for the doctor when she called his office, she spoke only with the physician's assistant who advised her to continue her medication

until her next visit. Her longest conversations with the doctor followed her procedures, when he told her the results of her tests.

Mary had a very supportive family of six siblings and multiple uncles and aunts, all of whom lived on farms they had worked for more than four generations. Her husband seemed resentful when she could not do her housework. He never discussed her illness with her physicians, and they never suggested he accompany her to the cardiologist's office so he could learn about her disease, its management, and her deteriorating course. As her health declined, her family insisted their general practitioner, who had known Mary for 20 years, find another cardiologist to offer a second opinion. Her family doctor recommended Dr. Cooper.

Dr. Cooper sat down with Mary and asked her about the course of her illness. She said there had been so many problems, hospital admissions, and tests she could not remember them all. With a little prompting, she told a story of progressive fatigue, no energy, and feeling tired all the time. When she tried to do housework, she had to rest between rooms. Just walking to the second level of her home was exhausting, and she had to sit on the top of the stairs to recover. She remembered at least three hospitalizations where she had repeat cardiac catheterizations performed. And all these events occurred despite scrupulously following her complicated medication schedule and diet.

Mary had the pale complexion of an individual with poor heart function. While she was overweight, she was not obese. Careful observation of the veins in her neck demonstrated she had not taken on too much extra fluid, and she was on the correct diuretic dose, always a concern in patients with heart failure. The apical impulse, usually easily felt in patients with hypertrophic cardiomyopathy, could not be felt at all. In addition, her very soft heart tones were another unusual finding. The unusual course of her illness despite standard treatment and her unexpected physical findings led Dr. Cooper to believe Mary had something other than the given diagnosis. Rather than repeat her tests, he reviewed what had been

done—her electrocardiogram, echocardiograms, and cardiac caths. He could see the progressive changes typical of a rare heart condition called primary amyloid heart disease.

Once Dr. Cooper was absolutely sure of the diagnosis, he felt he could provide Mary and her family with an honest and thorough assessment of her illness. Although the prognosis was dismal, he could still offer therapy to make her life easier. For one thing, she no longer had to feel her illness was a result of her failure to follow the doctor's directions. For another, after educating the family about her illness, they had a better appreciation of Mary's daily struggle to carry out her activities and were eager to provide the support she needed.

Dr. Cooper discontinued several of her medications, some of which were harmful, the others not necessary, and together with her family physician, developed lifestyle changes appropriate for her condition. On a simplified but more effective treatment plan, and with a more realistic outlook for her future, her family members and friends rallied around to provide support and comfort. Her daughter, who lived away from home, moved in to help care for her. Dr. Cooper promised to provide all the care and support she and her family needed and to be available to answer any questions they had. He also promised to continue to research the literature to be sure she had the opportunity to receive any new therapies as they became available. Fortunately, today new therapies are available for this once incurable disorder. For Mary there was no cure at the time, but she could be helped. Knowledge of the true disease process allowed her physicians to help her and her family understand her condition and what she required.

What Mary needed was a caring and empathetic physician willing to sit down with her and believe the story she had to tell. Her family physician, who knew Mary professionally and socially for many years, could now provide her medical care since no complicated medical regimen was necessary. Mary's trust and respect had to be earned and her story listened to otherwise, she would be no more satisfied with Dr. Cooper's opinion than with her first cardiologist.

While we cannot cure every patient, good bedside manners can relieve anxiety and show true caring for the patient. This supports both patient and family. If respect and trust are not established, the opportunity for healing is lost.

Mary's experience is far from unique. The single most striking change in medicine in the last 40 years is not the new, incredible, and astounding technologies, but the loss of confidence patients have in their physicians. *The New York Times* reported that when doctors are arrogant, patronizing, dismissive, callous, impatient, or judgmental, patients do not trust the diagnosis that results from their consultation or follow the recommendations they are given [3].

What must physicians do to earn back the trust of their patients? Dr. Philip Tumulty, in a 1978 speech to the Johns Hopkins medical students called "The Art of Healing," gave them some advice.

> A clinician must be patient and forbearing, strong yet gentle, unselfish of his time and unstinting in his efforts. He must be willing to bite his tongue and to turn his cheek. He must have an attentive ear as well as the ability to question probingly. His attitude must create trust and confidence, and his manner thoughtfulness and security. He must hear what the patient doesn't say and be sensitive to the anguish which cannot be expressed. Patients are anxious; they are frightened; they inwardly anticipate the very worst, although they may cover up with apparent lack of concern. Some are very brave, while others cling in terror. All grasp tightly to life, and in all, some glimmer of hope, no matter how flickering, is essential to the vitality of their spirit [4].

Changing Times Changing Behavior

For the first half of the last century, the social framework in organized medicine promoted cooperation, self-regulation, noncompetitive behavior, and collegiality. Court and legal academic challenges during the era of social and economic disruption from 1960 to 1980 claimed that such an organized network was nothing more than a means of monopolizing trade. Together with the increasingly large economic role of the federal government through Medicare and

Medicaid grants—plus anti-trust litigation against doctor groups and the influence of profit-driven managed care organizations—the ethic of collegiality and civility, while not eliminated, seemed to take a back seat to competition. Many healthcare organizations, responding to government and business communities, especially healthcare insurers, adopted business models that gave increasing importance to seeing more and more patients in less and less time. A profitable bottom line is the main concern of a corporation setting up possible conflicts with the principles of medical professionalism.

That said, we doubt if poor manners are a result of a deficiency in medical professionalism. Most of the colleagues and staff we have met in our three-quarters century of combined practices are well motivated and truly concerned about their patients. However, the change in behavior among and between doctors and between doctors and administrators of medical institutions, whether by coincidence or as a result of pressures to behave in a more business-oriented way, affects the way patients are seen and treated.

In the worst organizations, patients are dehumanized and become a commodity. On more than one occasion, we have heard patients referred to as "job security." When a doctor or nurse acts in a disrespectful manner, their behavior indicates a lack of knowledge, not only of what patients expect, but also of what is expected of them as healthcare professionals. Or perhaps rude physicians and staff are not aware of the messages sent by their actions. It is therefore important for healthcare professionals to "act the language," to behave in a manner to demonstrate they recognize their behaviors affect the healthcare of their patients. Recognizing the changes in the way patients are sometimes treated, organized medical education has instituted required curriculum in medical schools to teach medical professionalism to medical student and residents in training. Training in good manners and respect for their patients is part of that curriculum.

Trust in Patient Care

On what do your patients base their trust? They cannot reasonably be expected to perform an evaluation of your abilities, knowledge, or training. Other than the recommendations given by friends, who may have had one or two experiences with doctors, or other physicians' recommendations, the average patient has little information to evaluate the quality of care they receive.

They may inspect the diplomas hung on the wall and check out "health grades" and other online evaluations. Maybe they are impressed by pictures of their physician with civic leaders and celebrities who are presumably their patients. They may read the framed certificates from organizations with important sounding names. However, the most important impression is the one they form based on the way the doctor acts, the "bedside manner."

Patients cannot evaluate their doctors' surgical techniques, but they understand if the doctors are agreeable, neat, responsive to their questions, have a clean office, and treat their staff and are treated by their staff with respect. Clues and insights with which they leave the office will lead to expectations of care they will receive. Chances are patients are willing to grant a degree of slack for the state of the office surroundings, although the physical environment can say a lot about a practice. Patients may accept a waiting time if it is not interminable. But they expect the staff to treat them politely and in a civil way, and when it comes to the doctor and the nurse, the people to whom they literally and figuratively bare themselves, they expect a standard of behavior higher than what they might expect from others.

Consider the following from a leading American physician. In 2006, George Beller, a past president of the American College of Cardiology, wrote the following in an editorial in the *Journal of the American College of Cardiology*. His wife was suffering from a serious illness, and he made the following recommendations related to the behavior of the doctors responsible for her care:

> The patient should expect the physician to be caring and empathetic, take the time to explain what was found in the medical evaluation, describe the disease process in lay terms, not hurry when answering questions, show sensitivity and compassion when having to relate bad news, display a realistic but positive attitude about treatment plans, and fully explain why certain tests are being ordered and specific drugs or procedures are being recommended [5].

Dr. David Pendleton and co-authors, in the book *The New Consultation: Developing Doctor-Patient Communication*, identified the following five key issues a doctor should address for a consultation to be effective [6]. By "effective," the authors mean the consultation results in an improvement in the patient's health.

The doctor must: (a) understand the problem, (b) understand the patient, (c) the doctor and the patient must agree on the problem, (d) share decisions and responsibility, and (e) maintain a relationship.

Over the course of an effective consultation, patients should develop a firm understanding of what to do to improve their health and why. By following these recommendations, patients will increase their resolve and commitment to follow medical instructions. Keeping in mind that practical considerations do limit the amount of time a physician can spend with each patient, at the end of the consultation patients should leave the office satisfied that they have been encouraged to tell their whole story, that they were attentively listened to, and that they understood what was said and what further tests and treatments are to be done and why.

Together doctors and healthcare professionals make a social contract with their patients and all must be in agreement concerning follow-up plans. Although the physician is the medical expert in charge of the consultation, patients understand themselves better than anyone, and they are in charge of following the advice. If physicians do not have their trust and respect, it just will not happen. Patients must believe and understand the diagnosis and the plan to be able to effectively execute it.

Ninety percent of diagnoses can be made by listening carefully to a skillfully elicited history, yet Howard Beckman, MD,

and colleagues have shown that on the average, the patient gets interrupted by the doctor's questioning within the first 23 seconds [7]. In allowing patients to tell their story, they gain confidence that the doctor's care and will help them. Otherwise, they will not believe the doctors came to the correct conclusions about their illness.

Listening is important, but it is not only listening that improves trust in the doctor. A number of studies on physician-patient communication demonstrate that health outcomes are improved by verbal and nonverbal behaviors. How a physician dresses, facial expressions, how the patient is approached, and whether the doctor's attention is focused all play important roles in building trust and how likely patients are to follow their doctor's advice [8].

In his popular book *How Doctors Think*, Harvard physician Dr. Jerome Groopman notes that freedom of patient speech is necessary to reach a correct diagnosis and therapeutic plan [9]. Referencing other researchers, he notes how the interview process not only exchanges information between patient and doctor, but also establishes trust and "a sense of mutual liking." It is the "liking" part, based on mutual respect that results in improved patient follow-up or adherence to the therapeutic plan.

Looking back to Mary's story, at first she did not receive the correct diagnosis and an appropriate treatment plan. The diagnosis did not become clear until she had the opportunity to sit down with her new doctor and tell her complete story. The heartache and suffering Mary experienced were a personal loss, but the wasted doctor visits, unneeded and extremely expensive procedures, and excess medication are added costs, not just to Mary but to all healthcare consumers.

Doctor-Patient Relationship

Some of the negative views patients have of their doctors are due to failure to establish a relationship, and some are due to an estrangement of doctor and patient due to the deperson-

alization of medical care. Your patient may navigate the medical forms online, including a medical history, before even arriving at your office. Once there, they are asked some of the same questions they answered in the online questionnaire. When they finally get to tell their story directly to the doctor, usually in response to a variation of the question "What brought you here today," the doctor is frequently sitting at a desk facing a computer and typing responses into the medical record.

Once in the exam room, many doctors no longer make eye contact, act more like they are in a hurry, often do not ask their patients to disrobe, instead listening to the chest and feeling the abdomen over clothes. Patients are very aware when they feel the doctor is rushing and become suspicious when the evaluation is not thorough or meticulous. Lewis Thomas, now deceased, a respected researcher, teacher, and thoughtful observer from Rockefeller University, wrote in the *New England Journal of Medicine* noting that "medicine is no longer the laying on of hands; it is more like the reading of signals from machines" [10]. CT scans, PET scans, MRIs, and ultrasounds have replaced probing fingers and stethoscopes.

The physician, once the valued confidant and adviser for the family, not only assisted with the medical problems but also with the social and emotional ones. That physician is no longer in practice. Today's doctors are working just as hard and putting in the long hours but in a vastly different medical environment. Present-day practice is complicated by the demands of managed care, profit-oriented medical management companies, health maintenance organizations, and the need for increasingly focused specialty practices. Practices are divided by organs or disease types, such as neurology or endocrinology or cardiac surgery, and also by the location where the patients are seen: emergency department doctors, hospitalists, health maintenance clinic doctors, and multispecialty group practices. All this compartmentalization makes

an ongoing relationship with one physician more difficult and seem less and less important.

What has been lost in the rush to technology is the trust that is established by face-to-face time with the doctor and a sharing of secrets. Lost is the gentle yet expert physical exam where probing fingers identify and even reproduce an area of discomfort or pain, followed by a sympathetic response from the doctor. If a lump in the belly is carefully identified and circumscribed by the doctor's palpation, the patient's confidence in the examiner is established. If the doctor takes the time to listen carefully to the patient's chest, elicit the wheeze experienced the evening before, or have the stethoscope over the heart when it breaks out of normal rhythm, patients will be confident in their doctors' ability. If additional questions elicit symptoms not mentioned, both patient and doctor know they are on the right track. When a sympathetic nod acknowledges fears and presumptions, patients begin to feel a connection and confidence of growing trust.

Teaching the Lost Art of Healing

Bernard Lown, the famous Boston cardiologist, clinician, and Nobel Prize winner, expressed this opinion in his 1996 memoir *The Lost Art of Healing*: "The American public is suspicious, distrustful of, even antagonistic to, the profession" [11]. He comments that a doctor establishes credentials as a caring practitioner by listening attentively, and he sees the trust between patient and doctor, established over several millennia, slipping away. This lack of trust is not only a problem for the individual practitioner and the patient, the problem extends to the role organized medicine will play in the ongoing reinvention of the medical care system in America. Medicine as a profession needs to re-establish its position as a trusted adviser and steward of the patient's health, an invaluable partner in care, and an indispensable resource for the health of the community and the nation.

One opinion that has surfaced in our country's debate concerning the best way to finance our medical care is that a trusting personal relationship with the doctor is missing. We Americans take pride in believing we have the best medical care in the world even as the statistics for infant mortality, heart disease, patient satisfaction, life expectancy, and medical errors demonstrate otherwise. Newspaper articles air complaints about arrogant and difficult physicians; patients complain about missed diagnoses, inability to get appointments due to insurance policies, and doctors opting out of government programs that insure older patients or patients living near or below the poverty line.

Life-saving advances in medicine improve our health, and in the end, better health is what we all want. Today's doctors know more about the basic science of diseases, have more and better diagnostic tests and treatment options than ever before, and can help many more patients regain well-being than any previous generation of physicians.

Indeed, a first priority for most patients when choosing a physician or surgeon is their *perception* of the doctor's knowledge and skill. Yet many patients leave the physician's office dissatisfied and unconvinced. They believe their health is not the doctor's first concern. It is useless to diagnose an illness and recommend a course of testing and treatment if your patient does not trust your opinion.

A lack of confidence in scientific medicine is one reason Americans spend billions on alternative care, herbal medications, and even quackery. Often an uncomplicated illness can be rapidly diagnosed with a little patient history and an abbreviated physical exam. However, the respect and trust that should develop between doctor and patient during the office visit can make the difference in how determined the patient will be to follow up with diagnostic studies and treatment plans. When the longest conversation one has is with the billing office, or if your patients feel they never really got to know who is in charge of their

medical care, the likelihood they will closely follow your advice is diminished, and the outcome of the consultation will be less than satisfactory.

Threats to the Doctor-Patient Relationship

There are many reasons patient-doctor communication can break down. In fairness, the busy, overworked physician who has just administered to a terminally ill patient might not remember there are no trivial complaints and appear brusque to a patient with a URI. Each patient's complaints are important.

If you feel you are distracted, try to refocus all your attention to the person in front of you. If your patient is emotional, distracted, wondering, take a minute to address their immediate concerns. Consider a statement like "Mr. Smith, you seem distracted, is there something else you would like to talk about." If she is worried who will walk her dog, asking her to mention it will help refocus on the medical visit. If there is a serious problem, you have an opportunity to discuss it and in the end that will be important to your relationship. A patient may be in a heightened emotional state and not listening to or understanding what you are saying. The anxiety about their illness can cause so much discomfort they just want out of your office and away from the source of their unease about the illness and their mortality. For such patients consider asking them to bring a family member or a friend to accompany them to the office and the hospital.

You may have trouble communicating with your patient, or you may be asked the same question over and over. If your patient is not demented, then repeatedly asking the same question indicates their true concerns have not been addressed and possibly not even articulated. Try to encourage them to talk about how they feel or what else about their symptoms bother them. This may reveal the true concern. One of the goals of the consultation is to discover and resolve your patient's fears.

Set an Example

> Setting an example is not the main means of influencing another, it is the only means.
>
> —Albert Einstein

Professor Cheshire Calhoun writes in the essay "Expecting Common Decency" that the helping professions: medicine, nursing, and teaching, among others, "take on a special responsibility for promoting something of moral value that those outside the profession do not have a similar responsibility to promote" [12]. For doctors, this means behavior that exhibits caring, empathy, expertise, compassion, and a commitment to medical service. You can demonstrate all of those key qualities of medical professionalism during an office visit.

As an incoming medical student, you were selected based on academic performance in college. While the intellectual level of your classmates is universally high, humanistic values and social skills are difficult to assess from a college transcript or a written exam and may vary widely. Some entering students and physicians in training may need instruction in the language of manners as it applies to their patients.

Dr. William T. Branch, Jr., a professor of medicine at Emory University School of Medicine, demonstrated that faculty members coached on issues such as how to listen carefully, how to be a caring person, and how to use personal and social information in patient care were better at teaching these skills to medical students than faculty who had not been coached [13]. Interviewed by *The New York Times*, Dr. Branch pointed out that the skills taught to the faculty "can help physicians grow, not just in terms of knowing more but in becoming a whole person" [14].

Reflecting on his own hospital care, Dr. Michael Kahn, a psychiatrist writing in the May 2008 issue of *The New England Journal of Medicine*, noted that while compassion is preferred, most patients would be well served with a doctor who is well behaved. He wrote about his attending surgeon:

> I found the Old World manners of my European born surgeon—and my reaction to them—revealing in this regard. Whatever he might actually have been feeling, his behavior—dress, manners, body language, eye contact—was impeccable. I wasn't left thinking 'What compassion.' Instead I found myself thinking, 'What a professional,' and even (unexpectedly) 'What a gentleman.' The impression he made was remarkably calming, and it helped to confirm my suspicion that patients may care less about whether their doctors are reflective and empathetic than whether they are respectful and attentive [15].

Dr. Kahn goes on to describe a checklist, similar to the ones used by doctors and nurses when performing bedside procedures. He suggests using it when first approaching a patient. As he points out, it is easier to modify behavior than to change attitudes. Commenting on the best way to teach behavior to the student doctor, he writes, "Trainees are likely to learn more from watching colleagues act with compassion than from hearing them discuss it." Dr. Kahn includes in his prescription for better care the requirement that physicians be trained to pay attention to the patient. Listening, demonstrating attention to the patient's story, and engaging in a back-and-forth conversation are all dimensions of good medical manners.

Your training is long and difficult and very little time is devoted to teaching bedside behavior. The typical primary care physician spends 7 to 8 years in medical school and residency training before starting in practice, and the training periods for subspecialists can last as long as 11 years. Training is so demanding that medical schools and residency training programs are required by law to set limits to your working hours so you do not become exhausted or overextended.

In almost every other field, real-life experiences interrupt or end formal training. Adults barely out of their teens learn how to conduct relationships and how to behave in business situations from mentors much older and experienced than they, and from their peers by observing errors. Given the peer group and age of the non-medical school-bound college graduate, errors are forgiven and for the successful, not

repeated. A traditional medical student, because of a cloistered education, minimal socialization with peer groups outside of medicine, and mentoring in the clinical years by authority figures usually little older than they, can remain socially challenged when training is completed.

Medical schools have begun to recognize these deficiencies. Professors do lecture on the essentials of professional bedside behavior, and some medical schools have initiated courses on humanistic values including required readings in fiction and essays. Doctors in training are encouraged to present their patients in a humanistic manner rather than as a compilation of symptoms and diseases. They are instructed in medical ethics and receive lectures about right and wrong in terms of medical conduct. What is not taught is how the practitioner should behave in a manner that indicates to the patient what Dr. Calhoun calls the "moral attitudes of respect, tolerance, and considerateness." They may not be taught the nonverbal behaviors that demonstrate respect for the dignity of the patient, nurse, or colleague.

No other professional has the responsibility to ask for permission to poke and prod, elicit pain, or explore the most intimate areas of the body to help another individual. Out of the medical environment, such behavior would be criminal. This unique privilege makes the clear display of manners necessary to place the behavior in context and reassure your patient of your essential moral character. Medical manners communicate, in everyday professional behavior, the principles of medical ethics. Good manners signifying respect for your patient can be taught to both students and teachers. Dr. Kahn has it right when he emphasizes polite behavior over feelings. This is because conduct can be taught, behavior can be mimicked, and manners are teachable. Furthermore, repetitive actions yielding positive results can lead to fundamental changes in attitudes and beliefs.

Eugene Braunwald. Image Courtesy of the Lillian and Clarence De La Chapelle Medical Archives at NYU

Eugene Braunwald
Teacher, Scientist, World Leader in Cardiology

I was a student at the National Heart Institute at the NIH when Dr. Braunwald was the director and attended the regular meetings and conferences at the Heart Institute. He had a charisma and leadership that stood out even in the presence of the outstanding faculty and researchers in the institute. His insightful, original thinking, careful and thoughtful approach to experimentation, and organization and teamwork were on display with every project I observed during my rotation.

Eugene Braunwald was born in Vienna, Austria, in 1929. His nearly idyllic early childhood was suddenly interrupted in 1938 by Nazi Germany's annexation of Austria. After some harrowing experiences, he and his nuclear family fled Austria and came to London with literally only "their shirts on their backs." When World War II began, Eugene and his younger brother were evacuated from London to live on a farm in northern England. They emigrated to New York in 1939, where he entered the New York public school system and graduated as class valedictorian; attended New York University and graduated magna cum laude; and progressed to the New York University School of Medicine where he graduated in 1952 with the highest academic record in his class and received the student research award.

After 2 years of clinical training in medicine and cardiology at the Mount Sinai Hospital in New York, he served a postdoctoral research fellowship in the laboratory of Dr. André Cournand, a professor at Columbia University considered by many to be the "father of cardiac catheterization" and winner of the Nobel Prize in Physiology or Medicine. In 1955, he continued his training in the intramural research program of the National Heart Institute at the NIH, becoming chief of cardiology in 1961 and clinical director in 1966. His first wife, Nina Starr Braunwald (now deceased), became the first female cardiac surgeon and the first female member of The American Association for Thoracic Surgery.

In 1968, the Braunwald family (by then including three daughters) moved to La Jolla, California, where he served as the founding chair of the Department of Medicine of the new University of California, San Diego School of Medicine.

During his 4 years there, he established a strong department and demonstrated that he was an innovative medical educator, administrator, and academic leader. In 1972, the family moved back to the East Coast when he filled the post of Hersey Professor of the Theory and Practice of Medicine at Harvard Medical School, the oldest endowed medical chair at Harvard. He also became chair of the Department of Medicine and physician-in-chief of the Peter Bent Brigham (now the Brigham and Women's) Hospital. Under Dr. Braunwald's leadership, the Department of Medicine flourished; he recruited outstanding physician-scientists and trained two generations of academicians who in turn have exerted a major influence in academic medicine.

His first major article was published in Circulation Research in July 1954, and he has been a major force in cardiology ever since. Science Watch has listed Eugene Braunwald as the most frequently cited author in cardiology. On the basis of his contributions, he has received numerous honors and awards.

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Issues Addressed in This Chapter

- Respect and communication are key in a consultation.
- After a consultation, you and your patient should agree about the plan.
- Ordering tests is not a substitute for listening.
- Trust is established by face-to-face time with your patient.
- Listen to your patient, try not to interrupt, understand their concerns.

Study Guide

1. Why is respect for the patient important in caring for the patient?
2. How do good manners improve patient communication?
3. How did the doctor providing a second opinion for Mary C improve her care?

4. Consider Mary's first physician. What was his explanation to Mary about why she was not improving? Who did he blame for that? Why is that a problem?
5. What is your take away from Philip Tumulty's advice to medical students?
6. How do you gain the trust of your patient?
7. What is the social contract you make with your patient?
8. What are some of the ways a doctor-patient relationship falls apart?

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Chapter 6
Responding to Bias, Bullying, and Harassment

Wynne Morrison and Jessica Fowler

"I'm afraid there's a big difference between Doctors Without Borders and Doctors Without Boundaries."

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We are only as blind as we want to be.

Maya Angelou

Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.

Martin Luther King Jr.

Case Study

A medical student in her first clinical year rotates with a team supervised by the Department Chair of the specialty. After a few days working together, he says to her during a moment they are alone in a conference room, "I find you very intriguing." She is unsure if the comment is a compliment, a proposition, or both. She chooses to ignore it and changes the subject. She later wonders if she misinterpreted and missed an opportunity for academic mentorship, or if instead she successfully avoided a very uncomfortable situation.

- How would you have interpreted the Chair's comment?
- Did this student nimbly sidestep a possible fraught situation, or did she miss an opportunity?
- If she had pursued the conversation, what were the possible risks and benefits?

In 1982, the pediatrician Dr. Henry Silver published an article expressing concern about medical student mistreatment [1]. He noted that many of his students were eager and excited at the start of their training, but at the end displayed symptoms of cynicism and depression. He had seen similar personality changes in children who suffered abuse and neglect, and he wondered if abuse and mistreatment caused the changes he observed in his students. In 1990, he published a single-center survey of medical students [2], asking them about their experiences. He defined abuse as: "to treat in a harmful, injurious, or offensive way; to attack in words; to speak insultingly, harshly, and unjustly to or about a person; to revile." Forty-six percent of students in their early years of medical school stated they had experienced incidents of

abuse. Eighty percent of the fourth-year class reported an incident occurring at some point during their medical education. The most frequent year such episodes occurred was during the first clinical year.

Unfortunately, Dr. Silver's findings have not changed much, evidenced by the 2019 Association of American Medical Colleges (AAMC) survey in which 40.4% of medical students still reported some sort of mistreatment during their training [3], with female and non-white students more likely to report incidents. Other recent studies show almost 60% of students reported episodes of harassment or discrimination, with verbal abuse being the most common and physical harassment reported by 15% [4].

Recent events have focused greater public attention on the problems of bias, abuse, bullying, and discrimination of certain groups. The #MeToo movement, in response to sexual harassment and assault allegations brought against prominent individuals, helped many victims realize they were not alone in their experiences. It also highlighted the power structures that can keep victims silent.

The Black Lives Matter movement, in response to episodes of structural racism and violence, educated many about the long history of racial discrimination and injustice in the United States, as well as ongoing systemic inequities. While one would hope that medicine, with its commitment to the care of others, would be immune to problems of bullying, harassment, and abuse within its ranks, it is important to recognize that none of us are immune. Fifty-two percent of female and 5% of male medical school faculty have reported a personal experience of sexual harassment [Bates] [5]. More than 20% of underrepresented minority medical students (URM), compared to <4% of white students, report discrimination based on race/ethnicity [Hill, JAMA 2020] [6]. Bringing these problems to light is one of the most important steps we can take in order to address them.

In this chapter, we hope to add some diversity of perspective on the experiences of medical trainees. We both work in academic medicine, so our thoughts are informed by our own

experiences, those of students we know, and reports in the medical literature. We obviously cannot represent all perspectives on this issue. This is okay, if recognized and acknowledged.

One of the benefits of improving diversity in medicine is that all of you will benefit, throughout your careers, from engaging with curiosity to learn about others who are not like you. Whether those you are learning about are your patients or your colleagues, whether you are aware of your differences or not, we all benefit from an approach of open-minded inquiry. In medicine in particular, being inclusive rather than divisive is essential. The medical literature is full of studies examining the effects of bias and disparities on healthcare interactions, access to care, and outcomes. We will not be addressing the topic of clinical interactions at length in this chapter, although many of the points we make can apply in the clinical setting as well. We focus here on the impact of bias, bullying, and discrimination on medical trainees and describe programs and personal responses to begin to address these challenges.

History of Diversity in Medicine

Any discussion of the impact of bias and discrimination on medical trainees would benefit from an understanding of the history of diversity in medicine. The historical truism that the vast majority of physicians were male is reflected in the quotes from Hippocrates and Osler included in this book; consistent with their times, they refer to physicians as "he." For much of US history, that meant white men. While there is a history of schools that were dedicated to the education of black or female physicians, the standardization of medical education following the Flexner report (described in Chap. 1) had the unfortunate impact of closing many of these institutions [7] leading to a decline in gender and racial diversity of US physicians in the first half of the twentieth century.

The American Medical Association (AMA), founded in 1847, excluded a delegation of Black physicians to a post-Civil War national conference, citing concerns about the quality of their education and criticizing their professionalism because of lobbying efforts. Overt and subtle exclusion continued, leading to the formation of the separate National Medical Association (NMA) as a professional home for many minority physicians in the late nineteenth century [8]. Not until 2008 did the AMA apologize for its history of discrimination [9].

The Civil Rights era of the 1960s, ushered in profound changes to civil society and medicine. Medicare and Medicaid, passed in 1965, mandated integration in all US hospitals wishing to receive federal funds. Segregation in all areas of education, including in medicine, was challenged. While such efforts brought an end to formal "separate but equal" systems, many disparities in healthcare continued (and continue) to exist [Keppel x 2] [10, 11]. While the diversity of medical students continues to increase, students from some minority groups are underrepresented relative to the proportion of those groups in the general population [12]. This observation led the AAMC in 2004 to define the term "Underrepresented in Medicine (URM)" to distinguish groups with a lower proportion of individuals in medicine relative to the overall population and contrast them with some minority groups (e.g., Asian Americans) who are overrepresented relative to the general population.

Gender diversity is also changing over time. While there are accounts of occasional female physicians in ancient civilizations, for most of human history women served predominantly in allied health roles such as nursing and midwifery. In the United States, Elizabeth Blackwell was the first woman to be granted a medical degree in 1849 [13], and Rebecca Lee Crumpler was the first Black woman to become an MD in 1864 [14]. In recent years, the number of women matriculating to medical school has been roughly equal to the number of men.

For both women and URM students, however, there appears to be a "leaky pipeline." This phrase has been used to

describe the phenomenon that the percentage of women and URM physicians steadily falls the higher up one moves on the academic ladder. Leaders and senior faculty are less diverse than their students. As an example, in 2018–2019 women represented 50% of matriculating medical students, 46% of residents, 41% of full-time faculty, 29% of division chiefs, 25% of full professors, 34% of senior associate deans, and 18% of department chairs and deans. That percentage of women leaders is nearly double what it was in 2004, so change is occurring at all levels [15]. There is some variation between specialties, as women are the majority of current residents in OB/Gyn (83%) and Pediatrics (71%), but a minority in General Surgery and Orthopedics (26% and 19%, respectively).

The leaky pipeline is even more dramatic for URM physicians due in part to smaller numbers at matriculation. For example, the 2019 AAMC faculty roster reported that fewer than 2% of medical school full professors are Black [16]. As with women in medicine, differences of representation also exist based on specialty. URM physicians are better represented in primary care specialties [17].

How does this information add to the discussion of mistreatment and harassment? Some studies have shown an association between a lower proportion of female faculty and a faculty culture of "disrespect." While there is no guarantee that diversity leads to a culture of respect, there is a growing recognition that diverse teams can lead to better group problem solving and hopefully a better work environment.

We can both anecdotally attest to seeing changes over time. When Wynne was a medical student decades ago, she rotated at a community hospital where there was a "Doctors" locker room and a "Nurses" locker room, with obvious assumptions about the gender composition of each group. She stared at the doors wondering which she was supposed to use and decided it might cause a scene if she walked into the one labeled "Doctors." We suspect the signs have since been changed.

We have also seen targeted recruitment efforts to improve diversity among trainees at our institution. Programs to intro-

duce the health professions early to students from diverse backgrounds may be able to help overcome the challenge of having fewer senior mentors or "sponsors" available from similar backgrounds. This can build the pipeline of URM students who enter medical careers. Jessica participated in such a program the summer after her first year of college. Exposure to mentors, advanced coursework, MCAT preparation, and clinical time on the wards not only increased interest among URM undergraduates in the fields of medicine and dentistry, but aimed to make them more competitive in their eventual applications for such fields. The goal of such programs is to lead these students to become physicians, thus increasing the pool of diverse senior mentors over time. Recruiting efforts to enhance diversity throughout the ranks of academia will also help make sure students see many different models of success. Institutions and professional organizations are paying much more attention to these questions [NEJM] [18].

What Qualifies as Bullying or Harassment?

The U.S. Equal Employment Opportunity Commission (EEOC) defines harassment for legal purposes as "unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. Harassment becomes unlawful where (1) enduring the offensive conduct becomes a condition of continued employment, or (2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating [EEOC harassment]" [19]. For the purposes of workplace discrimination, in 2020 the U.S. Supreme Court upheld that the definition of "sex" as a protected category includes gay, lesbian, or transgender workers [de Vogue] [20]. Federal protections cover only discrimination and harassment for individuals in the above groups; state statutes will vary and can include additional categories. Institutions and employers may have their

own policies or guidelines that could lead to sanctions or loss of employment for perpetrators, even if there are no legal repercussions. The above EEOC definition also emphasizes that not all "unwelcome conduct" is necessarily unlawful.

The concept of "bullying" often raises memories of childhood bullies—individuals or groups who would single out others for negative treatment. Similarly, bullying in the workplace or higher education has been defined as repeated and systematic negative treatment that leads to victimization, stigmatization, and feelings of powerlessness in those targeted [21]. Bullying can have multiple impacts on the victim—psychologically, physically, and behaviorally. Institutions have an obligation to protect their employees or trainees not only because of legal and moral mandates, but also because bullied workers and students are less likely to be successful and productive.

Of course, bullying is not confined to the student-teacher relationships. Patients can also display racist and bullying behavior. Behaviors such as these will often be displayed in patients who are not responding to therapy or if patients insist on a particular intervention that has no or negative consequences.

A 72-year-old man with chest pain arrives in the ICU following evaluation in the emergency department. The resident physician on call for the night enters the patient's room, introduces himself and starts the admission process. The resident is of Chinese-American background.

- The patient barks at him: "Where are you from?"
- "California," the resident answers.
- "Yeah, right. You can't be my doctor."
- The resident stops, trying to decide how to respond, when the supervising fellow on call, a Black woman, walks in and introduces herself.
- "You *really* can't be my doctor!" the patient then exclaims.
- The resident holds his breath, wondering what his fellow will say.
- She stays calm. "Sir, I imagine it is distressing meeting so many new people when you are in pain. We are the team

on call tonight, so we will be the doctors taking care of you. I promise you that we will keep in close touch with your primary physician so the doctor who knows you best will stay informed. If you aren't happy with your care team here, you can request transfer to another hospital, but I worry that would put your health at risk."

- The patient grunts and shrugs, and lets them complete the rest of the admission history and physical.

In a difficult interaction with a patient or their family, one has to exhibit equipoise and understanding. However, patients will only exhibit this behavior if they believe it will achieve their goal. Sometimes that goal is not immediately obvious.

How did the Fellow handle the interchange?

What should the resident have done if the Fellow had not shown up at that moment?

Should the resident switch patient responsibilities with one of his colleagues? Explain your reasoning.

When Silver first called attention to medical student mistreatment, some argued that criticism and verbal attacks were an inevitable part of the process and even suggested such strategies would help students learn better. We have definitely seen this occur in medicine—a professor quizzes the student to the point of discomfort or embarrassment in front of others and defends the behavior as "helping them learn." Is this mistreatment or bullying? Or even legal harassment? When does it cross the line?

From our perspective, even a harsh tone or nasty comment can be counterproductive. It may rise to the level of bullying if it is frequent and repeated. Environments in which such routine negative interactions are tolerated have been shown to be associated with medical student burnout (See Chap. 10) [Cook] [22]. Such behaviors may qualify as harassment when and if they are persistent and clearly abusive, if they target individuals or groups because of who they are, or if there is a quid pro quo (e.g., sex for good grades). It may also be a sign of bullying if the person in power seems to enjoy belittling others.

Hierarchy and Its Relationship to Harassment and Bullying

In considering the hierarchical nature of medical training, it does not seem surprising that the first clinical year is the time medical students report the most mistreatment. They are the least experienced clinicians on the team and are therefore error-prone, unfamiliar with the team routines, and at the lowest rung on the ladder in terms of power dynamics. These power dynamics can magnify the problem because the victim may feel powerless to object. If a student tells a professor that a comment makes her uncomfortable, will her grade be impacted? If a resident complains to the program director, will he not be able to get a letter of recommendation? Students and trainees are by definition in vulnerable positions. This vulnerability means that special procedures need to be in place to protect them from retaliation when needed.

As a personal commentary on the potential influence of hierarchy, Wynne can attest that the frequent inappropriate comments and actions she endured as a young, single, medical student rotating through various specialties (at a time when men outnumbered women at her school) have almost entirely disappeared now that she is an experienced, married faculty member working in a pediatric setting. The passage of time or geographic location may have also had some impact on this change, but progressing from a student to leader of the team seems like the most important contributor. We raise this point to emphasize that it is important for those in leadership positions to remember what it was like to be in the more vulnerable position of being a student or trainee and advocate for systems that give a voice to those at most risk of mistreatment.

Responding to Bias, Discrimination, or Harassment

Both individual responses and structural/systematic changes are important to address the impact of bias and discrimina-

tion on the culture of medicine. Students and trainees may wonder whether it is wise to respond if they witness inappropriate comments or actions, and many will hesitate to escalate concerns to a higher administrative level.

Two points can help empower those who hesitate. One is the realization that no one is free of any biases whatsoever, so we can all help each other learn to improve. Another important point is that confronting or reporting an egregious offender, as difficult as it may be, may help protect others in the future, not just yourself. One of the biggest realizations of the #MeToo movement was that sexual assault is often a repeated pattern. If victims of discrimination, harassment, or assault realize they are not alone, they may also gain the strength to help others by speaking up.

As an example, Wynne recently heard from a student who struggled while working with a subspecialty fellow who made frequent demeaning comments and unreasonable demands. When Wynne shared her perspective (as a former program director) that the faculty in charge of education in that subspecialty would *want* to hear about this behavior, the student decided to raise her concerns with the clerkship director. It turned out that other students had similar experiences, and their collective willingness to speak up helped the program leaders identify that an intervention was needed.

In recent years, there have been efforts to improve education regarding "implicit" or "unconscious" biases. The AAMC states that such biases are "attitudes or stereotypes that are outside our awareness and affect our understanding, our interactions, and our decisions. Researchers have found that we all harbor unconscious associations—both positive and negative—about other people based on characteristics such as race, ethnicity, gender, age, social class, and appearance. These associations may influence our feelings and attitudes and result in involuntary discriminatory practices, especially under demanding circumstances" [23]. Psychologists developed the *Implicit Association Test*, a rapid-fire sequence of associations to attempt to bypass the analytical side of the brain, and many who take such assessments are surprised to find they are biased in ways they did not expect [24].

The benefit of the implicit bias framework is that it acknowledges that people with good intentions can clearly have biases that affect others. This insight can also help someone who wants to challenge an inappropriate comment or statement, and inform how to frame their confrontation with the responsible party. Criticizing the action rather than the person, acknowledges the offense may not have been intentional, and that we all have room to improve. This can be much more effective than shaming. An example of a useful phrase might be: "I know this may not be the way you intended what you said to come across, but I thought it would be important to let you know how it made me feel …" Critics of this approach point out that one cannot abdicate individual responsibility with the excuse that since the bias "is unconscious, it's not my fault."

There are also concerns that such approaches do not address the structural causes of systematic racism or sexism. Some institutions are investing in "bystander intervention training," acknowledging that all employees (or students) in an organization bear some responsibility for the culture [25]. Such training equips those who witness discrimination or harassment with strategies for speaking up in order to avoid enabling problematic behavior by their silence. In a sense, this call to action reflects active allyship, empowering not only those who may be the target of bullying or bias to speak up but calling on those nearby to also lend their voices to address the situation. The goal is to avoid normalizing the toxic environment.

A staged response is often appropriate. Start with humor (but be clear the offensive behavior is not welcome). Tenney offers some suggestions such as responding to comments like "Your English is so good!" with a response such as "I should hope so since it's the language I've been speaking my whole life!" [26]. A next approach can be to ask questions that explore the comment or behavior, such as "Do you know how that sounds?" As Tenney emphasizes, make it clear you were surprised by

the comment and move next to state you (the bystander) are made uncomfortable by it. Use direct communication, but avoid making assumptions about the offender's intentions or beliefs. Escalate to a higher level of reporting for egregious, repeated behavior if the offender does not respond to the above interventions.

Every school should have a reporting structure, hopefully one where confidentiality can be maintained, for students to raise concerns—rotation or program directors can be a great start, and deans, diversity officers, or ombudspersons should also be available. These leaders almost always want to hear if there are problems that need to be addressed, and typically prefer to be able to do so in a timely manner before difficult behaviors escalate.

Some organizations have also begun to focus on "civility training." Civility, or "manners," as the editors have discussed throughout this book, can make a difference, both in promoting a culture of respect and in responding to instances of disrespect (see Chap. 3). Courage is needed to challenge an offensive comment with civility; that is, in a way that respects the offender and assumes the person is capable of learning and growth. We truly believe that doing so is both the right approach and the most effective approach. The Internal Medicine Department at Duke University describes a program with "Civility Champions" and a robust reporting structure [Duke] [27]. Such programs hope to foster an environment of respect and understanding among colleagues. A commitment from leadership and consistent messaging is a key driver of an inclusive culture.

Structural Changes

In addition to individual interventions and education, it is also important to structure systems of care and education in such a way that diversity is not only valued, but treasured. Explicit efforts to enhance diversity in leadership are one

step towards culture change. Such efforts should include not only recruiting an administrative leader to be in charge of diversity and inclusion, but also efforts to bring diverse voices to the table throughout leadership.

The following occasion drove home this point. A young physician from a URM background served as an at-large member of a healthcare organization's Board of Directors. At a Board meeting she voiced her concern that security was more likely to be called when non-white patients or families raised their voices during disagreements than for similar behaviors on the part of white patients or families. When the institution looked into the issue, it turned out her suspicion was well-founded.

Increasing diversity throughout the ranks in medicine will also hopefully help physicians identify institutional and cultural assumptions that impact education and patient care. As one student recently pointed out, she needs to learn how to perform CPR on a woman (but all the mannequins were male) and how to detect rashes on dark skin (but all the photos in the lecture were of light-skinned patients) [Nolen] [28]. If more of us share our stories as she did, we can raise awareness of the many subtle and not-so-subtle ways in which we make assumptions about our patients and each other.

Conclusion

Returning back to Silver's initial observations about mistreatment, those who care for victims of child abuse know that neglect can have long-term negative consequences just as active abuse can. Ignoring bias, bullying, harassment, and discrimination can lead to a culture that perpetuates disrespect. Joining together to ensure a culture that is accepting, inclusive, and diverse can improve the work and educational environment for all.

Elizabeth Blackwell

Pioneer and Humanitarian

Elizabeth Blackwell was the first woman in the United States to receive a medical degree, in 1849. Born in England, she moved to America with her family when she was 11 years old. Her family, of a Quaker background, had a history of fighting against slavery and for women's rights. Her father devoted equal resources to educating her and her four sisters as he did to her brothers' schooling. She began her studies with an interest in history and philosophy, but is reported to have turned to medicine after a dying friend said she would have been better cared for by a female physician. Her father died when she was 17, and all the girls had to figure out ways to contribute to the family finances. After acquiring significant self-education by reading in the libraries of physician employers and family friends, she decided to pursue medical training. Many told her it was a futile pursuit. She applied widely to medical schools, receiving rejection after rejection because of her gender. One physician even advised her to disguise herself as a man in order to apply. She was eventually accepted to Geneva Medical College in New York. Reportedly the student body, asked to vote on whether they would accept a female classmate, voted unanimously "yes" as a joke. She graduated first in the class, however, despite being initially ostracized. In 1857, she was one of three women to found the New York Infirmary for Women and Children, focused on the care of the poor. The clinic offered a setting for female physicians to practice and educate others, eventually founding an associated school. She was an innovator in

medical training, developing a longer and more rigorous program for training physicians than was common at the time. Her sister Emily also became a physician and joined her in practice. Decades later, their school merged with Weill Cornell Medical College. She worked at various times in England, France, and New York, and was a friend of Florence Nightingale. She was also the first female physician on the British Medical Register. She was a long-time advocate for education of girls and felt that women could be a strong influence for morality in medical culture. She published her autobiography *Pioneer Work in Opening the Medical Profession to Women* in 1895. She said, "It is not easy to be a pioneer- But oh, it is fascinating! I would not trade one moment, even the worst moment, for all the riches in the World."

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Photograph Library of Congress #2005679734

Daniel Hale Williams

Trailblazer, Innovator, Teacher

Daniel Hale Williams was a pioneering Black physician born in 1856 in Pennsylvania. He initially trained as a cobbler and then followed in his father's footsteps as a barber, but decided he wanted to pursue further education. Interestingly, there is a long history of barber-surgeons in Europe, since both fields required skill with and ownership of sharp blades. Williams apprenticed with a surgeon and next trained at Chicago Medical College. He started a practice as one of only three Black physicians in the city and was able to teach anatomy at his Alma Mater but was denied hospital admitting privileges because of his race. In 1891, he founded the nation's first integrated training hospital for interns and nurses, Provident Hospital. He was one of the first surgeons known to have operated on the pericardium, saving the life of a trauma victim. He was also an early proponent of aseptic technique. In 1913, he was elected as the only Black charter member of the American College of Surgeons. He was later surgeon-in-chief at Freedman's Hospital in Washington, D.C., and a faculty member at Meharry Medical College. He and a group of Black surgeons were denied membership in the American Medical Association because their local medical society was restricted to White physicians. They therefore joined others in advocating for a professional organization for Black physicians, and he served as the founding vice-president of the National Medical Association.

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Nanette K. Wenger, M.D.,
M.A.C.C., M.A.C.P., F.A.H.A.

Advocate for Women's Health
Mentor to Women Physicians

In 1958, when a young Dr. Nanette Wenger (NW) became the chief of cardiology at Grady Memorial Hospital, patients were separated by race. Over the PA system, white patients and white nurses were addressed as "Mr. or Mrs." followed by their last names, while Black patients were called by their first names only. Black nurses were simply called, "nurse." Patient charts had a "C" or "W" next to the names. For Dr. Wenger, a native of New York City, this way of doing things needed to change immediately**.** "I was in charge of the clinic, and I said, 'This is not the way we are going to be doing things,'" Wenger insisted Black patients be addressed as "Mr." or "Mrs." And all nurses regardless of their race be addressed by their name. When an administrator warned she was breaking hospital protocol, she would not budge. Then Wenger got called into the director's office. "Do you really know what you are doing?" "Yes," she answered. "Are you going to keep doing this?" The answer again without hesitation: Yes. "You come with a set of core values," she said. "I had never lived in the segregated south. I couldn't accept people not being treated as equals."

Dr. Wenger would become a giant in the field of cardiology. Her ground-breaking research has led to new medical treatments and changed a major paradigm in cardiology: the assumption that heart disease affects only men. At Harvard, in the sixth class that included women, she was introduced to emerging laboratory and research techniques. In 1956, she was the first woman to be named chief resident in cardiology at Mount Sinai Hospital in New York.

It was also a time of major changes in the care of heart patients. In the late 1950s, most doctors prescribed 3–6 months of strict bed rest and delayed a cardiac patient's return to work for up 2 years. But Dr. Wenger had noticed patients could recover more quickly by getting up and moving around—starting with sitting up in bed, and then walking around the bed, and then walking down the

hall and so on. At Grady, she developed a 21-day cardiac rehabilitation program which became the model for programs across the country. By the mid-1970s, there was a growing amount of research focused on heart disease, but it was almost all exclusively done on men. And the assumption, she said, "was that women were just like men, so why bother studying them?" She zeroed in on the small number of women included in studies, and even by studying that small number, she saw gender differences—in symptoms, risk factors, diagnostic tests, and outcomes. Doctors too often fail to take a woman's risk seriously or treat it aggressively. And doctors often do not discuss ways to help prevent heart attacks in women. A landmark *New England Journal of Medicine* review article that Wenger coauthored in 1993 was based on a conference at the NIH. It summarized many years of research to show just how dire the situation is—women are more likely than men to die soon after a heart attack and during hospitalization. They are older and sicker when they do receive treatment, and more often have other health conditions, such as diabetes and hypertension. By then, it was also becoming clear that women died from heart disease in far greater numbers than men. Many women did not realize that heart disease is their No. 1 killer.

In 2020 at age 88, Wenger is still a rock-star physician. She has authored or coauthored over 1600 scientific and review articles and book chapters. She continues to treat patients, research heart disease, and flies around the world to give lectures [1, 2].

Helena Oliviero The Atlanta Journal Constitution December 12, 2017
Personal Communication with Dr. Nanette Wenger
Photograph courtesy of Dr. Wenger

DR. Rafael Campo

Physician, Poet, Advocate

Dr. Rafael Campo tells a story about arriving as a student at Harvard Medical School in the late 1980s. Apparently, he was never made to feel out-of-place as a young, Latino physician-in-training at the prestigious institution. And no one looked surprised when he told them he was gay (although he did not "come out" to his parents until he was nearly done with school). But when he said he was a *poet*, there were some who wondered what he was doing in medicine. His joke makes light of the truth he has also written about—how alone he felt before he began to talk publicly about his sexuality. When he began to join in advocacy efforts, he said, "It was empowering to know that my voice could be heard—that it

was *essential* that it be heard. That changed my life [Gibson]." Dr. Campo was raised in New Jersey, where the family relocated after his parents had to flee Cuba. He often felt like an outsider growing up. While he was fascinated by science and medicine, he also gravitated towards the humanities and took time off from his medical training to pursue a graduate program in creative writing. As a resident physician in San Francisco, he cared for many patients dying of HIV/AIDS at a time before the disease was as treatable as it is today. He has proven that an individual's impact can grow out of being one's authentic self—having now published seven books of poetry, having received a Guggenheim fellowship and the Lambda literary award, and having been named as poetry editor of the *Journal of the American Medical Association.* He is a primary care physician and faculty member at Harvard.

His patients have often inspired his writing, and he feels that it is important to give them a voice in this way. He hosts workshops in which he shares poems whose writers have thought about life and death, sickness and health as a tool to help struggling patients realize they are not alone. He resolved to be different than professors early in his training who discouraged emotional connections with patients, and is happy to see how much more medical schools seek to foster empathy in students these days. Harvard now includes a course for medical students focused on the humanities, which Dr. Campo believes can help protect against burnout.

Illness
Imagine that the bed is not a bed
And illness is a cave, the bags of blood
Stalactites, the doctors eyeless fish-
Imagine that an illness is a cave
From which the body must emerge, but can't
Because the flesh is always so forgetful,
Because a certain greed has brought it there-
A vein of gold, the River Styx, a dream,
Persephone-imagine that the bed
Is not a bed, that God is waiting white
And glorious, and that the beach, which stings,

Is limitless and has no name except
Romance, or sex, just throbbing there all white
Like Marilyn Monroe, Madonna, God
It *hurts,* and then the medication, beds
Everywhere, the cave deepening, the cave
A smile in the Earth: she knows the time
Has come, and she remembers everything.

"Illness" from *The Other Man was Me* by Rafael Campo. Copyright 1994 Reprinted by permission of Arte Publico Press.

IATROGENIC
You say, "I do this to myself." Outside,
my other patients wait. Maybe snow falls;
we're all just waiting for our deaths to come,
we're all just hoping it won't hurt too much.
You say, "It makes it seem less lonely here."
I study them, as if the deep red cuts
were only wounds, as if they didn't hurt
so much. The way you hold your upturned arms,
the cuts seem aimed at your unshaven face.
Outside, my other patients wait their turns.
I run gloved fingertips along their course,
as if I could touch pain itself, as if
by touching pain I might alleviate
my own despair. You say, "It's snowing, Doc."
The snow, instead of howling, soundlessly
comes down. I think you think it's beautiful;
I say, "This isn't all about the snow,
is it?" The way you hold your upturned arms,
I think about embracing you, but don't.
I think, "We do this to ourselves." I think
the falling snow explains itself to us,
blinding, faceless, and so deeply wounding.

"Iatrogenic" from *Alternative Medicine* by Rafael Campo. Copyright © 2013 by Rafael Campo. Reprinted by permission of Georges Borchardt, Inc., for the author.

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Photograph courtesy of Dr. Campo

Scenarios for Discussion

A medical student is spending a year working in a laboratory at a prestigious research institute in a large city. He walks to work from his apartment a few blocks away. Almost every day as he enters the campus, the guard at the front gate asks to see his employee ID. After a few weeks in the position, he begins to notice that almost no one else walking in is stopped by the guard. He is frustrated, assuming he is being stopped because he is Black. He mentions it to no one other than a fellow student, and begins to lose some of his enthusiasm for the research training program.

Study Questions

- What about this student's experience might be related to unconscious or conscious bias?
- How might you respond as the fellow student who has this story shared with you? How could you support your fellow student?
- What are the potential consequences of dealing with ongoing discrimination/bullying/bias in your learning environment?

A medical student is on her core surgery rotation. She is scrubbed in for a surgical procedure, assisting a senior attending physician at the institution. After quizzing her throughout the case, he says to her: "Hey, little girl, are you going to bake me brownies like that other little girl did last week?" She panics internally for a moment, but then says, "No, sir, I will not be making you brownies." He laughs and says he can tell she is making better use of her time reading. She thinks about his reputation as an outstanding teacher and advocate for trainees, and wonders if some students are mentored or "sponsored" more than others.

Study Questions

- Are there a range of possible responses to this comment? How would humor have worked (e.g., "My brownies might kill you!")? Or challenging even more directly? (e.g., "I don't appreciate the way you're saying that.")
- What power dynamics are at play in this interaction?
- How do you think this student would or should respond if this surgeon offers to serve as a mentor for her?

A senior fellow in infectious diseases is exploring grant opportunities to fund the last year of her fellowship, as salaries for this research year of fellowship are not guaranteed by her training program. She has read studies suggesting male applicants are more likely to be successful obtaining grant funding, as well as others citing concerning levels of burnout in female physicians. Her male co-fellow was recently awarded funding for his research and is working with a senior faculty member in the division. She has a 7-month-old son at home and adjusting to parenthood with her long work hours in fellowship has been more difficult than she expected. She wonders if she made a poor career choice.

Study Questions

- Which of the challenges this fellow is facing could be examples of unconscious bias?
- Are there structural or societal factors that may affect her career choices or advancement?
- Is it a concern if women or minority physicians make choices about their career paths (e.g., part-time work or non-academic practice setting) that work well for them but are less likely to lead to future leadership opportunities?

An intern is eager to begin training at a new hospital and excited to connect with his new colleagues. The Program Director has invited all of the trainees to an outdoor event and encouraged the interns to bring their families and significant others. Despite his excitement, the intern has held off on RSVP'ing for the event because he is not sure if he is ready for

his co-residents and program leaders to meet his partner. He does not want to offend his boyfriend who just moved with him across the country for the start of this training program, but he is also unsure of how his new colleagues will respond.

Study Questions

- Are there systems the program could put in place that could help new interns feel less alone in situations like this?
- What is different about disclosing sexuality when compared to how one would feel if one were one of few women or minority students at the event?
- What might be different if the student were in a mixed-race rather than same-sex relationship?
- Is there any way the intern can finesse the situation without feeling singled out or offending his partner?

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Part II
Providing Quality Care

Chapter 7
A Welcoming Office

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First Impressions

First impressions are important and your patient's first experience in your office will affect your ability to reach the correct diagnosis, influence their decision to follow your advice, and return for follow-up. As you conduct the office consultation, your patient will be carefully noting your body language, tone of voice, and whether you make eye contact, sometimes to the exclusion of what you are saying. William Osler recommended an attitude of "aequanimitas" when caring for a patient; that is, an imperturbability or calmness and tranquility that is reassuring and supportive.

Body language expresses how you feel and what you think. Be cognizant of how your body is reacting. You must appear engaged; restless behavior can be perceived as disinterest or impatience. Make eye contact with your patient. A smile upon meeting is important to establish the rapport and trust that makes you seem approachable, empathetic, and interested. Refer to your patient by their correct and preferred name, and use it several times in your interview. We recommend you use their formal name at the first encounter and only ask their preferred name after you have established a relationship.

Manners Matter

Too often, basic manners and politeness are neglected. Saying "please," "thank you," "you are welcome," "nice meeting you," and "we are going to take good care of you" goes a long way to establishing a good doctor-patient relationship.

The essential action in every encounter is listening. Actively listen**,** ask your patient questions about themselves, and in a deliberate and positive manner respond to their answers. People like to know you are not only interested in their disease but want to know them as individuals. If you are comfortable doing so, and if it is appropriate to a shared interest, it is okay to talk a little about yourself including

some of your finer moments, your interests, and family; this will show you are involved and genuine in your interest. Just be careful not to monopolize the conversation.

The main purpose of the visit is to listen to your patient's concerns so you can take appropriate action. Listen for your patient's unique characteristics and record them in your note so you can mention them on each encounter. Consider examples such as your patient likes to play tennis, her spouse is ill and she is the caregiver, he enjoys his volunteer work. Patients want to feel you are interested in their lives. Using their name and asking about their interests and family are very helpful in developing your relationship and rapport.

How you conduct the conversation is important. Be careful not to speak too loudly or forcefully. Use a soft but easily heard voice. Do not appear to dominate or control the conversation. Be aware of the tone of your voice; be friendly, enthusiastic, and involved. Avoid an apathetic, disinterested, or nonchalant response.

Be prepared when you are interviewing a new patient or have a follow-up visit. Review whatever details you can. Many new patients are referred from urgent care, emergency rooms, or other practices, so be diligent in collecting and reviewing those records. Most practices today request patients submit medical information online or by email before a new visit, so review that material before you walk into the room. Patients are understandably irritated when they have completed extensive forms about which their doctor seems to have no knowledge.

Your patient's time is as important as your own. Be on time. People rarely forgive having to wait and as a first impression it suggests you are irresponsible and unreliable. Being on time is about self-discipline and self-respect; it is the courteous compliment a caring physician pays to their patients. Osler said, "Punctuality is the prime essential of a physician—If invariably on time he will succeed even in the face of professional mediocrity" [1].

How you look and what you wear matters. When your hair is unkempt, or if, heaven forbid, you have a body odor, or

your nails are ragged and dirty, your clothes do not fit, are too casual or revealing, your patients are affronted and annoyed. Clean your hands in the exam room before and after the visit; patients notice. Dirty hands, unprofessional dress, and unkempt appearance all interfere with a successful doctor-patient consultation.

Talk to your patient in simple, clear, easy-to-understand language, and be careful to avoid medical jargon. Speak clearly and slower than in usual conversation. Enunciate your words and avoid using slang or inappropriate language. Listen to your patient's complete story; avoid interrupting or redirecting. This is true even if it is not the story you are interested in hearing. If your patient was referred from the urgent care center for evaluation of chest pain, and the story you hear is about headaches, let them finish; it rarely takes more than a few minutes. Then you can question about the chest pain, which may not even be a bother anymore. But interrupting often leaves the patient feeling they were unable to comfortably communicate their story. Not being listened to is a common complaint of an unhappy patient.

It is okay to show off your personality. If you are funny, and the situation is not life threatening, include some spontaneous humor in the conversation at an appropriate time. Patients will relate to you in a more open, honest manner when they feel your humanity. Many of your patients will have seen other physicians. Some will have undergone invasive treatments and therapies. Never criticize your fellow physicians. You are certainly not aware of all the facts, and your criticism will undermine your patient's confidence in medicine and may interfere with accepting the appropriate tests and therapy you recommend. For the most part, individuals practice medicine at an extremely high level of competence and are superbly trained, and unlike some other professions, this level of competence is worldwide.

It is important to be positive when your patient is about to leave the office. Included in this book is a chapter on hope. We encourage you to read it. Be sure your patients leave your office with awareness that you have provided some hope. This

may not be hope for a cure, but you can reassure them you will support them through their illness, work to alleviate their symptoms, and most of all communicate what is happening to them.

Lewis Thomas in his 1983 book *The Youngest Science* wrote, "The sagacious, avuncular physician who used to make house calls [and] look after the illness of every member of the family [is gone]… The doctor-patient relationship was, for better or worse, a long conversation in which the patient was at the epicenter of concern and knew it. [If] I were a medical student or an intern, just getting ready to begin… I would be apprehensive that my real job, care for sick people, might soon be taken away, leaving me with quite the different occupation of looking after machines" [2]. This advice is as wise today as it ever was. Technology is an ever more important and essential part of caring for our patients, but you must be sure it supplements your care and does not replace the art of medicine.

Why Is the Patient Here?

Your patient's first scheduled visit to your office as an independently living adult is often prompted by a specific complaint, a worried spouse or co-workers, or a referral from an urgent care center or emergency department. If they are ill or injured, in all likelihood they will have an opinion of what condition is causing their symptoms. This opinion is strongly influenced by family, friends, and any information in the media or cyberspace they are able to access. Perhaps their mother-in-law has arrived at a diagnosis and wonders if you will agree with her; the spouse or roommate certainly has some idea of what illness the symptoms point to, and friends may have insisted they can save your patient a trip to the doctor's office. Then there are those opinions and diagnoses from the Internet. All these opinionated, self-appointed experts are in the examining room with you as your patient strips to the buff. You have to listen to these and tease out the patient's true concerns.

In many cases, patients do not come to see you just because of their symptoms, rather they are more concerned with what they believe the symptoms mean. After all, chances are pretty good that mole on their abdomen is not all that bothersome, but if a family member died of skin cancer, they start to examine the mole carefully in the mirror, searching for changes in shape, color, or size. Is it really bigger, darker, or is the border less regular? They are not sure, but they are worried it could be a melanoma or something else serious.

That pain in their shoulder does not hurt except when they swing a tennis racket. This will not interfere with their usual activities, but since the league season is about to start, they are concerned the pain will interfere in their ability to play.

The backache they have been experiencing for the past several weeks is not all that severe, but your patient is on his feet all day at his job, and his coworker just had spinal surgery and was out for 3 weeks. This is not something he feels he can afford. It is not just the symptom, but also how the symptom will affect your patients' lives that brings them to your office.

Your patient wants you to take time for explanations and to ask about and pay attention to their real concerns. As the physician, you have to become involved, not just in the diagnosis and treatment but understanding and demonstrating concern for your patient's health by asking what worries them most and why. Your patient will also have some expectations of what you will do or say. They may be right, somewhat off base, or totally misinformed, but as David Pendleton and colleagues point out [3], any consultation that fails to take into account their expectations is less likely to be satisfactory. When you sit and listen to your patient's story, appear interested, and want to learn more, their estimation of your character and wisdom increases.

In any other setting, if someone wanted to dominate a conversation by discussing their health, they would be cut off as a bore. When their doctor sits and listens, leans forward, eyes wide, interrupting only for clarification and then only

when necessary to keep the patient on track, there is a feeling of interest and caring. A polite and agreeable doctor is more likely to do a better job at communicating recommendations, and without question your patient will feel better about following them.

The Importance of Empathy

In his book *How Doctors Think* [4], Dr. Jerome Groopman writes, "[W]e all want to feel that our physician really likes us, sees us as special, and is emotionally moved by our plight, attracted not so much by the fascinating biology of our disease but by who we are as people". Show empathy by encouraging your patient to name how they are feeling. Ask if they are angry, depressed, frightened, or feeling alone, for example. Then do not rationalize that feeling away and never say "I know how you are feeling," as that minimizes their distress. Rather, express some appreciation of their experience with the feeling, such "I am so sorry for you," or "we are here for you," or "what can we do for you right now?"

The doctor who demonstrates empathy and communicates an intense desire to provide the best possible care will get the best results.

Medical schools and the hidden curriculum teach students to remain emotionally detached from their patients because emotional involvement can color decision-making, cause burnout, and result in inaction when a life-saving maneuver requires a life-endangering procedure. Emotional involvement can even lead to inappropriate social interactions. However good manners and courteous behavior, not to be confused with emotional involvement, do not get in the way of excellent professional judgment and medical care. Recognizing this, over the last several years medical school curricula have included courses in medical humanities as a way of exposing students to the ideas of empathy and compassion in the healing arts.

Patient-Doctor Relationship

As David Pendleton and colleagues write in their book [5], the most successful physician visit is a collaboration between equals. Physicians have expertise on the science of medicine, and patients are experts on how they are affected by their symptoms and the limitations social environment places on their ability to follow treatment recommendations. The following case example illustrates many aspects of an expensive and unhelpful office consultation.

Martha W. considers herself a successful businesswoman, wife, and mother. She has a rewarding career as a real-estate agent, and is always near the top of her office in sales. She understands the importance of listening to customers and is proud of her knowledge of the real-estate market. Skillful at identifying her client's needs, she works hard to also satisfy their desires. She appreciates the importance of being on time and well prepared for appointments. Having sold homes to new physicians just beginning their practices and to established physicians enjoying professional success, she is comfortable around doctors and appreciates their long hours and difficult work schedules.

Bothersome abdominal cramps and bowel irregularity prompted a visit to her internist, a physician who had provided her care for 20 years. Her internist referred her to Dr. Mark G., a gastroenterologist in a large subspecialty group. Dr. G. enjoyed a wide reputation among his colleagues as an excellent diagnostician and for his skill in the endoscopy laboratory. Of peripheral interest is Dr. G.'s unconventional public image for a medical professional. After his second divorce, he was mentioned in a local magazine as one of the area's most eligible bachelors.

On calling his office for the appointment, Martha was advised to be early in order to complete the necessary paperwork. Here is the story in her voice.

"When I made the appointment by phone, the doctor's assistant asked me to arrive 45 minutes early to fill in insurance and history intake forms, which I did. I found the sign-

in sheet in front of a closed, clouded glass window labeled 'Reception.'"

"I filled in the requested information and waited another 15 minutes before I saw any of the doctor's staff. The office furniture looked old and worn, the magazines were laughably ancient, and anyway the room was so dimly lit and the TV so loud I could not have read. Finally the receptionist appeared and asked me to fill in an eight page form asking for my health insurance, current complaints, past medical history, and any other problems I might be having and medication I was taking."

"When they finally called me, I had waited for an hour. They placed me in a small exam room, gave me a paper gown and asked me to completely undress. I waited another 30 minutes in that chilly room for Dr. G. He wore a scrub suit, wrinkled and stained on the front with what I hoped was catsup, and a soiled lab coat that was probably white at one time, but now had a dull gray tint. Both mustard and catsup stained the sleeve edges of his lab coat."

"He seemed rushed. He did not offer his hand, and I don't think he smiled once during my exam. Instead of coming over to the exam table where I was sitting, he went immediately to a computer, sat down in front of it, and alternated flipping through the forms I had filled out and tapping on the keyboard. After a few minutes, he asked me how long I had my symptoms and what medicines my family doctor had put me on. Then he asked me many questions about the pain, how long I had been on the two drugs my internist recommended, had I lost weight, was I having any emotional issues. All in less than 5 minutes, all without looking up from the computer. I didn't have time to think about my answers, but it was all on the form anyway, except the emotional issues."

"Then he asked me to lie down and the gown opened up. I was embarrassed, and I said the gown doesn't work well. Not that I meant to complain. I just wanted him to know I'm not an exhibitionist. He looked at me as if I were an idiot and told me I put it on wrong, that it opens in the back. Now I was not only embarrassed, I felt stupid. Then without a word he

started to poke my belly here and there, asking me if it hurt. I tried to tell him his hands hurt, but if he was trying to get the pain to come back, he didn't. He said, 'Unh hunh, unh hunh,' but I'm not sure he understood."

"I will say he was very thorough in his exam, but he did not say anything despite spending a whole lot of time with a lump in my groin I didn't even know I had. After finishing the exam, he went back to the desk and restarted tapping into the computer. Finally he looked up at me and told me to get dressed. I don't think I've been naked for that long since my honeymoon, if then. The gown was ripped in several places, and what I really wanted to do was dress in private. I mean, how do you have a conversation when you are stark naked except for a few paper tatters and standing in front of a man who is completely dressed?"

> "'We're going to have to run a bunch of tests,' he said.
> 'What are you looking for?' I asked.
> 'It would take too long to explain it, and anyway, the only important thing is what we find.'

"Apparently my condition was top secret, and I was on a need-to-know classification.

> 'And what do you think that will be?' I asked.
> 'I can't really say until we run all the tests. My nurse will schedule the procedures and blood work and answer any questions.'"

"Procedures? No one mentioned any procedures. I didn't want to talk to the nurse. I wanted to talk to the doctor. He was the one who had poked his gigantic finger up my butt. Then he wrote out two prescriptions but never really told me how to take them or what they were for, and by this time I was too intimidated to ask. I had to ask the pharmacist."

Martha left the office anxious, angry, confused, discouraged, and frustrated. What should she do? A physician she trusted had referred her; other physicians she knew attested to the consultant's knowledge and skill. Her confidence in the specialist had been high when she entered his office, but his physical appearance, the office environment, the behavior of the staff, and most significantly, the physician's manners alien-

ated her. Not only that, she felt she had failed to convey all the information the specialist needed to make a full diagnosis.

She never returned for the procedures and instead asked her internist to refer her to another doctor who confirmed the diagnosis of irritable bowel syndrome. The time and money spent on the visit was wasted, Martha's problem was no better, her faith in her long time internist was tested—he had to apologize for the referral—and Martha's opinion of doctors and the medical care system in general suffered a blow.

The story presents numerous deficiencies in patient care, but maybe the most egregious is not listening to the patient's story. The loss of the patient narrative represents more than just discarding an inexpensive but effective diagnostic technique. Martha did not come to the office to receive a slip for blood tests and medication. She wanted to engage the doctor in her problem and have him care about her symptoms. Martha was looking for empathy and compassion in addition to a diagnosis and treatment. She did not find any of it.

It is not enough to be bright, well trained, and experienced. F.W. Peabody, a legendary physician of the early twentieth century and active in the founding of the Harvard Unit at the Boston City Hospital, wrote in a famous 1927 essay, "One of the essential qualities of the clinician is interest in humanity, the secret of the care of the patient is in caring for the patient" [6].

Martha's treatment in the waiting and reception area, the level of housekeeping, the demeanor of the staff—all seemingly minor niceties—had health consequences. Then she met Dr. G. He communicated his attitude toward his patient through his actions: inattentive listening, unwelcoming demeanor, and treating Martha as "just another patient." True or not, it seemed as if he did not care if Martha followed his recommendations.

Listening to the patient's story is both good manners and good medical practice. When it comes to medical care, attentive listening can make the difference between getting a diagnosis right or wrong, or as in Martha's case, can seriously influence the willingness of your patient to proceed with further tests and stick to your prescribed medical regimen.

The extra consideration and planning that could have resulted in learning more about Martha's condition, and in Martha's understanding of the role of the prescribed medication and tests, was missing from her visit. As a result, she failed to follow-up. Fortunately, she had a good relationship with her internist and went back to him for additional care, but she could just as easily opted out of the medical care system and resorted to self-diagnosis and self-treatment, delaying appropriate therapy.

Placing the Patient First

You have probably not received any course work in medical school on managing a medical office. The lessons learned by the hospitality industry, and almost every consumer-oriented business in America—say hello and thank you, be thoughtful and courteous, and care about your customers' feelings and opinion—have not carried over to patients in doctors' offices. In some clinics, the convenience of their physicians seems to come first, and staff has the opinion that only the physicians' medical knowledge, skills, and patient outcomes are important.

You have been taught in medical school that the patient always comes first, and that is true, but you cannot put your patients first if your practice fails economically. Medical offices operate under conflicting pressures. As every retail operation knows, the customer must be happy, but who is the customer in the medical office? You would think it is the patient, of course, but frequently it is also the insurance company, the hospital or outpatient surgery center where you refer your patients, or the physicians who refer patients to you.

We are not economists and cannot start to solve the economic puzzles of delivering medical care. The reality as we see it, in consumer terms, is that the patient is at once the product and the consumer. If there is a disconnect between the business bottom line, medical care, and your patient's

comfort and convenience, your service will suffer. What we can do is encourage you to place your patient's care first, smoothing and enabling their experience while they receive your medical care.

We would encourage you to consider the following recommendations when you open an office or join an established practice. Provide an office that is welcoming. It has been our sad personal observation that this goal is rarely met. Your patient's first contact with the office is a phone call to make the appointment. Although cost considerations make the use of an automated telephone system a necessity, it is frequently a source of irritation and frustration for many patients. No one wants to leave a message about what they consider a serious or urgent medical concern, much less an intimate problem, on an answering machine. The new patient should be able to quickly bypass the system and speak with a sympathetic and unhurried attendant. Your credibility as an empathetic and caring practitioner will suffer a big hit if your patient's first contact with your office is no more personal and no less frustrating than a computerized help line.

Consider your patient's mood when the waiting room is extremely plain and uninviting, the reception staff is curt and unfriendly, or the wait is long with no effort made to inform your patient of the reason or the time until they will be seen. The medical office, along with the DMV, post office, and the jury waiting room are among the few places left in our modern, consumer-oriented society where the average person will routinely encounter employees acting in an offhanded, indifferent, or rude and disrespectful manner, and where a work-related goal appears to be unpleasant personal encounters. Your patient is not likely to be openly communicative when you enter the exam room if the nurse has been rude or you seem rushed.

A smiling and welcoming member of the staff should greet patients. Names should not be called from a door 20 feet away from where the patients are waiting. This is rude and embarrassing. In a large practice with a common waiting area, a system of grouping patients by doctor or time slot

will allow the nurse to come within a few feet of the patient before calling out a name. Even better, taking a lesson from restaurants, you can notify your patient by a text message on their cell phone. A nice courtesy is for the nurse to escort the patient from the waiting area to the next stop on the journey, with the patient setting the pace. If your patient is disabled, be sure your staff asks if they would like to use a wheelchair.

If you have been running late and your patient waited a long time to be seen, apologize for the delay before you begin. Before they leave the office, have one of your staff ask if they have any ideas to help avoid waits in the future. Tell the staff member to take notes. In one of our offices where patients are scheduled every 15 minutes, 8–12 patients are seen every morning or afternoon. Of course just an extra 5 minutes with each patient will mean another 40–60 minutes in office hours, and then there is the issue of some patients needing more time. Let your patients know they will not have to wait if they schedule their appointment as the first patient in the morning or afternoon. At the very least, you are recognizing their angst. Of course, if you find you are always running late, then you need to be honest and schedule more time with each patient, even though that means fewer patients per day. Excessive waiting is a recurring complaint and will not benefit your reputation. If your patients frequently complain of waiting to be seen, take a deep breath and a mental time-out, apologize, and work with your staff to resolve the problem.

The next story illustrates an all-too-common example. Mr. K. is an 87-year-old retired lawyer. He is on chronic oxygen therapy and undergoes hemodialysis three times a week. His life now centers on visits to his cardiologist, nephrologist, the dialysis center, physical therapy, and the pacer clinic. A rather calm individual, this day his annoyance boiled over. Arriving on time for his appointment, he had to wait over an hour to have his pacer interrogated, a procedure that takes less than 30 minutes. The waiting area had no attendant, no TV, no reading materials, and the furniture was uncomfortable and cheerless. The setting for the scheduled procedure, the hos-

pital cardiology center, caused Mr. K. to question the quality of his medical care. For all the millions spent on the latest technology, the hospital spent little to improve his experience.

Waiting, Waiting, Waiting

Judith Martin writes in her book, *Miss Manners' Guide to Excruciatingly Correct Behavior,* "it is uncivilized, wicked, unconscionable, barbarous, and unethical the way the medical profession [habitually] keeps patients waiting." She comments (sarcastically, we hope) that "doctors have so much in the way of the world's riches that it is not necessary for them to have manners" [7]. She implies that the practice of medicine is organized in a way to make rude behavior the norm.

As the French say "*Men count up the faults of those who keep them waiting."* Sharon Schwarze, writing in the *Journal of Clinical Ethics,* indicates it is not only unethical and disrespectful to be late, being late for an appointment breaks a binding oral agreement [8]. There are, to be fair, many reasons you may run late. These might include unexpected delays in starting or completing procedures, medical emergencies, the late arrival of scheduled patients, unforeseen phone calls from the hospital or patients, and there are more. What is not acceptable is poor office management, over scheduling, and inconsiderate and contemptuous concern for your patient's time.

Your office staff can help. They should keep your patients posted as to how late you are likely to be. A general explanation of the reason reduces frustration. Be honest and remember patients understand medicine and the nature of patient emergencies, complicated and prolonged procedures, and the demands on your time. Most of your patients want you to give priority to someone who requires immediate care to prevent permanent disability or worsening condition. Make sure your staff never uses an excuse such as "the doctor is at an important meeting," or "the doctor had a family emergency," or "one of the doctors is not in today so your doctor had to

double up." Every excuse should be related to something medical. If a significant delay is expected, and significant is a relative term, the staffer should offer a new appointment, if practical, rather than force your patient to wait longer. If you notice your patients are bringing their own reading materials or a Kindle, you should be concerned you are keeping them waiting too long.

The Patient's Medical History

There is no doubt medicine has seen incredible advances over the past decade in advanced diagnostic and therapeutic technologies, yet the importance of the patient's history has not diminished over time. Obtaining a complete history is essential for the correct diagnosis, but listening to the patient, really listening, is also necessary to develop the confidence and trust of a good relationship. Every experienced clinician can relate multiple stories of a missed diagnosis due to inadequate history taking. Here are a few.

Jake R., a 48-year-old with a diagnosis of a myeloproliferative disorder, was clinically stable with mild splenomegaly. He regularly traveled by air to one of America's most famous medical centers to be cared for by world-famous hematologists. Over a period of 3 months, his spleen increased in size, he lost weight, he became weaker, and increasingly ill. His physicians reassured him his myeloproliferative disorder was stable. Yet his symptoms progressed until he needed hospitalization. In the hospital, a hematology fellow took his history, found out Jake was a spelunker and immediately recognized he could be suffering from disseminated histoplasmosis. This was the correct diagnosis, and Jake responded to liposomal amphotericin B.

Mira F., a 68-year-old female with recurrent chest pain, thought she suffered from indigestion and gastroesophageal reflux. Despite several visits to her doctor and nearby emergency departments, her discomfort did not lessen. Multiple tests, including ECGs, demonstrated no abnormalities, but

treatment for reflux brought no relief. Mira's primary care doctor referred her to a gastroenterologist for a procedure. The GI doctor obtained a complete history. Mira's pain worsened after meals and when she walked upstairs to her bedroom. The GI doctor insisted on a full cardiac evaluation. Mira suffered from severe proximal obstruction of the left anterior descending coronary artery.

Stuart A., a psychiatrist, had a long history of low back pain. He was diagnosed with lumbar spinal stenosis and underwent three operations before he received relief. Ten years later, he experienced increasingly severe back pain associated with a marked decrease in energy and a mild anemia, both attributed to his advanced age and worsening of his condition. He went back to the physiatrist who had treated him for a year after his surgery. He again started physical therapy and pain-mitigating medications. After a year, his symptoms became disabling. He decided, with the physiatrist's encouragement, to schedule an MRI in preparation for a revisit to his neurosurgeon. The radiologist's report highlighted bony lesions in Stuart's pelvis, consistent with Hodgkin's lymphoma. A careful physical exam to find the cause for Stuart's lack of energy and mild anemia might have demonstrated an enlarged spleen and lymph nodes before the disease had spread to Stage IV. Chemotherapy resulted in remission of the Hodgkin's lymphoma and some improvement of the back pain.

Begin your interview by asking as general a question as you can. "What brings you here today?" "How have you been feeling lately?" "What are you concerned about?" If your patients offer a self-diagnosis such as "I have indigestion, or bronchitis, or a cold," insist they describe their symptoms and let you consider the diagnosis. Try to maintain an open-ended interview as long as possible. Use directed questions only to help them open up and share a complete history. Take the necessary time to know and understand their concerns.

Walt M., a 36-year-old non-smoker, presented to the teaching service with severe chest pain and a presumptive diagnosis of acute myocardial infarction. His coronary arteriogram

demonstrated no obstructions. He did not abuse drugs, lived a healthy lifestyle with no risk factors, and had a negative family history. The residents could not understand why he had the episode, whereupon the attending asked him for the exact events leading up to his pain. Walt said the onset of pain came just after he received some legal papers. When asked the subject of the papers, it turned out they were the final divorce papers from his wife, whom he still dearly loved. He had experienced a Takotsubo heart attack, an event associated with severe emotional distress. The extra 5 minutes to hear this patient out saved a lot of time and money, assisted in the diagnosis, improved patient compliance, and increased patient satisfaction.

We know time is precious. It helps if your patient is prepared. Encourage them to write down and bring their concerns to the office with any medical records they have. Yes, sometimes they bring more questions than can possibly be answered in a single office visit. If that is the case, it is appropriate to cull out a reasonable list of their greatest concerns and suggest they make another appointment so you can answer all of their questions, if still necessary.

At the end of the interview, your patient should feel you have listened to their complete story, answered most if not all of their questions, and provided written instructions concerning the diagnosis and treatment plans.

The Physical Exam: Naked Patients

It is easy to take off all your clothes... People do it all the time. But opening up your soul to someone, letting them into your spirits, thoughts, fears, future, hopes, dreams...that is being naked [9].

The physical exam is among the most important responsibilities of the physician. As the above quote notes, there are many ways to see a patient naked and the doctor is privy to most of them. Patients share their stories about their fear of dying, the misery of their illness, the sadness of their addic-

tion, the unhappiness of being too fat or too thin, then they expose their bodies to you. For many patients, this is unpleasant; the ravages of age, illnesses, deformities, or just the embarrassment of being naked in front of a stranger elicits multiple feelings, most of them uncomfortable.

Patients are more at ease being interviewed with their clothes on. An exam gown can leave your patient feeling exposed, and may result in reticence to tell you about their symptoms and illness. Interviewing your patients while they are completely dressed may not be the most time-efficient manner to organize a practice, but it is in your patients' best interests.

When you ask your patient to undress you have to balance your need to complete a good examination with sensitivity to their feelings. The internists who complete a thorough exam will ask their patients to completely undress and provide a comfortable gown to cover their nakedness. What is not acceptable is a flimsy paper drape. The surgeon may only want to expose the abdomen, the orthopedist the knee, and the pulmonologist the chest. Most doctors will use a gown that opens in the back and can be adjusted to carry out a careful exam without unnecessarily exposing the patient's most sensitive areas. It is not necessary to do a complete examination on every patient, but it is essential in some. Keep in mind the first rule of the physical exam is adequate exposure and a quiet, well-lighted room to auscultate the chest, heart, and abdomen. Examining patients through their clothes is not optimal.

The exam room should be kept warmer than the offices and waiting area so your patient is comfortable. It should not be necessary to note that the offices should be spotless and the examining room tidied after each patient. However, lighting is sometimes ignored. The offices in general should be well-lighted and cheerful, but the exam room should be bright. Although privacy in the waiting area is a challenge, there is no excuse for a lack of privacy once the patient has entered into the back offices and exam area.

Chaperones

In 2017, news outlets reported extensively on sports physicians sexually abusing their patients [10]. In 2018, the *Atlanta Journal Constitution* continued their report on physicians molesting patients and found such behavior occurred at a surprising rate [11]. It is the responsibility of doctors to ensure their patients feel safe, and to that end healthcare organizations have formal chaperone policies [12].

One of the main themes of this book is the need to maintain mutual respect between doctor and patient. That is not a simple matter when the patient is naked. In the absence of an organizational policy, it is the responsibility of the individual physician to ask if patients would like a chaperone to be present during an examination. Document the request and response in your note. Information about patient's rights, including chaperones, should be highlighted in all introductory information offered in the office and the hospital. We encourage family and friends to be with patients during the office visit, but they do not substitute for a chaperone. Some patients, after brief discussions, do not feel a chaperone is necessary, and this should be documented in the note. We do strongly recommend the presence of a chaperone in the case of a breast or genital examination, or if there is any question of your patient's comfort and security.

Completing the Consultation

In many practices, the consultation is completed in a separate office, after the physical exam, where you discuss the tentative diagnosis and your plans. An efficient office staff will prevent the doctor from feeling rushed or interrupted during this time. This means scheduling should be realistic, calls should be managed, and your manner unhurried and bright. Interruptions affect the thinking process and communication. Your patient may forget to mention a problem, or feel intruded upon. Keep in mind that both you and your

patient value your time together. Stay focused in your questions and attentive to the responses. Keep your cell phone in the off position; you cannot expect your patient's complete attention if you do not give your complete attention to the consultation.

At the end of your consultation, you will discuss your opinion and recommendations for diagnosis and treatment. This is a mutual process. You supply your expertise in medicine and your patient contributes their knowledge about themselves and what they feel is happening to them. The late Dr. Barbara Korsch, a professor of Pediatrics at USC in Los Angeles, studied the consultation process throughout her career [13, 14]. She terms the education part of the consultation a "joint venture." She points out that during this part of the consultation your patient's need for information as well as what they think is needed must be addressed and the information given must be relevant. Encourage your patient to speak freely. Often patients will have their own idea about what is causing their illness or how they should treat it. These ideas may or may not be correct, but if you fail to discuss them, or do not take those ideas into consideration, it is likely your patient will leave the office dissatisfied and unlikely to follow your recommendations.

As we saw with Martha W., satisfaction with the consultation is critical to following the treatment plan. Patient adherence is one of the main goals of the medical consultation. In the medical journal *Primary Care,* the researcher Dr. Glyn Elwyn summarizes the doctor's tasks necessary to achieve patient compliance or adherence [15]. If the consultation is considered a team effort, with you and your patient working to reach a successful conclusion, your tasks might look like the following [16]: Why is the patient here? What are the real concerns? Discuss how the problem affects the patient and what you think might help. Come to an agreement as to what the problem is. With complex problems, this can become a negotiation. Be open. Respond thoughtfully. Make sure you have listened carefully; make sure you understand your patients' specific needs, and they can carry out your instructions once they leave your office.

Before they leave, urge them to repeat in their own words the information you have given them, especially about medications and follow-up. It is often helpful to have four sets of ears; encourage your patient to bring a spouse or sibling or good friend, so if they are confused they can review what was said with someone else who accompanied them. Finally, be sure they leave the office with written instructions.

Anyone Can Improve Patient Care

It helps if you have an unhurried manner, a bright, positive attitude, and are courteous and supportive to your staff. Interruptions do occur no matter how hard you try to avoid them; some are emergences and sometimes staff and associates feel their time is more important than yours. If you are interrupted or called out of the room, apologize. When you return, review what you have been discussing carefully, considering all the relevant concerns. Try to stay focused on the narrative and attentive to responses to your questions. Do take calls from a hospital nurse and any physician-to-physician calls. This is because direct communication with the medical caregiver is essential for good patient care, although this may require the interruption of a patient interview. A confident and buoyant doctor and staff can go a long way to encouraging patient adherence, while any rudeness is likely to discourage adherence and create animosity and dissatisfaction.

Social Media: Use and Abuse

You are more than likely a member of at least one social network and probably have been for a number of years. Now that you have started your healthcare training, or are well into the process of developing your professionalism, you must re-evaluate how you use all digital media.

Most medical professionals communicate via encrypted email with their colleagues and many use social networks as a private, personal messaging and sharing media with colleagues, close friends, and families. In a survey of one suburban pediatric practice, 8/12 pediatricians received requests for connections on social media, and 3/8 fielded enough of those requests to consider it a problem. None of the twelve pediatricians had their own separate social media account for professional purposes [17].

A good general recommendation from the American College of Physicians (ACP) and the Federation of State Medical Boards (FSMB) is to use email "only for patients who maintain face-to-face follow-up" [18]. In other words, any patient clinical email correspondence should only be between well-established patients and their doctors on secure networks. Given that caveat, there are some other good rules to follow.

Before using any sort of digital communication with patients, you must ask for permission to send and receive information. Most practices now use encrypted "patient portals" to communicate administrative functions such as scheduling, filling out forms, and to respond to patients' questions. Using an encrypted server properly set up by a professional IT person will obviate many of the potential difficulties associated with digital communication. The problem for patient and doctor alike is the patient portal is often less convenient than typing in a text message.

There is some discussion in the literature and ironically on social media about the use of unsecure media to communicate anonymous patient information with colleagues [19], and allowing patients to access personal social media accounts [20].

The use of social media offers opportunities for discussion and clarification of a relatively new mass technology in an established professional environment [21]. Plastic surgery can be particularly instructive for all specialties, because the line between medical education and medical entertainment/advertising can be easily crossed.

You must receive permission to use both an encrypted and an unsecured server, just as you must receive permission to leave medical and all personal information on a telephone answering device. In general, use your professional email address via a secure server to communicate with patients and treat the interchange in the same manner as a telephone call, i.e., enter the interchange into the patient's medical record. Never ever use any digital media to post negative statements. Relationships change, political alliances shift, the potential for personal gain can lead to destructive behavior. Remember this alliteration: "Posted once, Present in Perpetuity (3Ps)."

If you feel you have become professionally close to your patient, and you are the main physician responsible for your patient's care, then you can offer your personal cell phone number. However, this should only be done if you give explicit advice on how you want your patient to use that number. We have given our cell phone number to the families of patients we managed in the CCU, ICU, NICU, and PICU if we determined the patient would be staying for an extended period. This offered the patient's family great peace of mind and was rarely abused.

If you are part of an organization (as are all medical students and trainees), carefully review your institution's policy about social network use. These policies are not tips, or guidelines, or optional. They are enforceable policies that you transgress at your peril. You should have a separate persona, for the purpose of posting private material, complete with all privacy settings active [22]. This persona should be identifiable only by those you wish to view the information. Think of it as your nom de plume.

Even on your private site, the 3 Ps apply. Your posts on social networking sites are not strictly limited to those who have access to either your personal or professional digital persona, despite all the privacy settings. Anyone (e.g., the nurse or doctor who is your ex, the attending who does not want you on the service, the medical student you "pimped" earlier today) can take a screenshot of your post and share it at their will without your knowledge. Your persona on the Internet, personal or professional, must never be inappropriate.

One fact we learned when we were researching this subject came as a shock. Google automatically pulls available information from your social media accounts and displays it in the Google search for your name. It is important to make sure a simple Google search cannot immediately direct patients and colleagues to your social media posts. That is especially true of any posts you might have made before you decided to become a healthcare professional or before you updated your privacy settings [23].

If permitted by your institutional policies, you may use text messages and email to communicate with colleagues. However, if you mention a particular patient's name or unique features that can be used for identification, you must only use direct voice-to-voice telephone or an encrypted text messaging or email server. Again, remember; never, ever be judgmental or negative. This includes any attempts at humor—no matter how humorous you may think you are (it is never that funny in court), or how frustrated.

We fully expect our more media-facile colleagues will have some excellent ideas about ways to use social networking that further the precepts and ethics of professionalism. Here we offer some basic ideas on how to use social networks to improve your patients' and your community's health and not transgress the demands of professionalism.

- Think of using social media the same way you might consider using a TV or radio interview, a health information TV show, or a newspaper article. You can talk to the audience and disseminate accurate health tips, but the audience cannot talk to you.
- Consider posting an easily understood article, usually less than 750 words, on pertinent health issues applicable to your patient population or the community at large but within your area of expertise.
- Present important medical breakthroughs in a format the general public will understand.
- Present timely pieces on current health issues. A good idea is to include references to reliable Internet resources geared to the lay public.

- You can use social media to announce the use of a peer-reviewed, new, accepted medical or diagnostic technique or therapy your practice has adopted.

Being in a social network is a bit like attending a family reunion. Your immediate family, while they pile onto the picnic lunch, has now informed the other 250 members of your dearest and closest relations that you just got accepted to TopTier University Medical School. Now second cousin Horace wants you to diagnose the pain he gets in his chest when he plays one-on-one basketball with his son. Aunt Suzie, bless her heart, wants to know if it is really true that smoked ham is not a particularly healthy red meat alternative.

It is best not to offer advice at this party, or the gathering will be even more tedious than you expected. Ditto on social media, and there you stand the chance of incurring a lawsuit for the most innocuous response.

For some, social media can be very seductive. One can post the results of a self-funded clinical trial rejected by peer-reviewed journals, or an anecdotal experience using an untried medical therapy, or a favorite homeopathic treatment that has not received any sort of clinical test other than your own experience. Do not succumb to this temptation.

Once you have completed your training, you may decide you would be most content in a practice unaffiliated with an institution. Self-promotion can be valuable to both you and your community and is acceptable if it embraces the best uses guidelines of the ACP/FSMB. You must not violate any rules of patient confidentiality or professional conduct. You should not post preliminary or non-peer-reviewed information for the general public to see. This is not considered acceptable. Social networks can also be misused to vent against a particular institution or individual. Any declamation against a public figure or institution that you cannot document and has not received vetting by a trusted news source is very unprofessional and does a disservice to you and to your colleagues. Any public venting about a private individual is not only unprofessional, but in most cases will invite a lawsuit.

Despite warnings in the medical literature that are now almost 10 years old [24], inappropriate online posts by medical students and residents continue. In a study done by Koo and associates, Facebook was queried for publicly accessible profiles using the names of all urologists graduating from US training programs for the year 2015. Unprofessional or potentially objectionable content was prospectively identified using widely accepted professionalism guidelines. Of those graduates with public profiles, 40% of the profiles contained questionable material, and 13% showed explicitly unprofessional behavior [25]. An official complaint about such material to a medical review board would ruin a career. While this is unlikely to happen, inappropriate material posted by individuals identifying themselves as physicians or nurses casts a very poor light on their colleagues and on both professions. You have a debt to your fellow students, your mentors, and the support you have received from your benefactors and society at large. No matter how cool or comic you may think such posts are, they are not.

And finally: Social networks' risk avoidance.

- Stay away from your cell phone and your computer when you are intoxicated.
- If the question enters your mind: "Is this post appropriate"—it is not.
- To paraphrase the surgical maxim: When in doubt, leave it out.
- Do not give advice outside of your specialty.
- Do not engage requests for advice on unencrypted networks.
- Do not post any piece with identifiable patient information, including unique medical details which other patients in your practice may be able to link to a specific patient.
- Do not post a piece that is tailored to a very small population of your patients: They will be known by their disease characteristics and their doctor.
- Stay away from your cell phone and computer when you are intoxicated (yes, we know we repeated this crucial piece of advice).

- From a 1906 children's book: *Better to Remain Silent and Be Thought a Fool than to Speak and Remove All Doubt*[1].

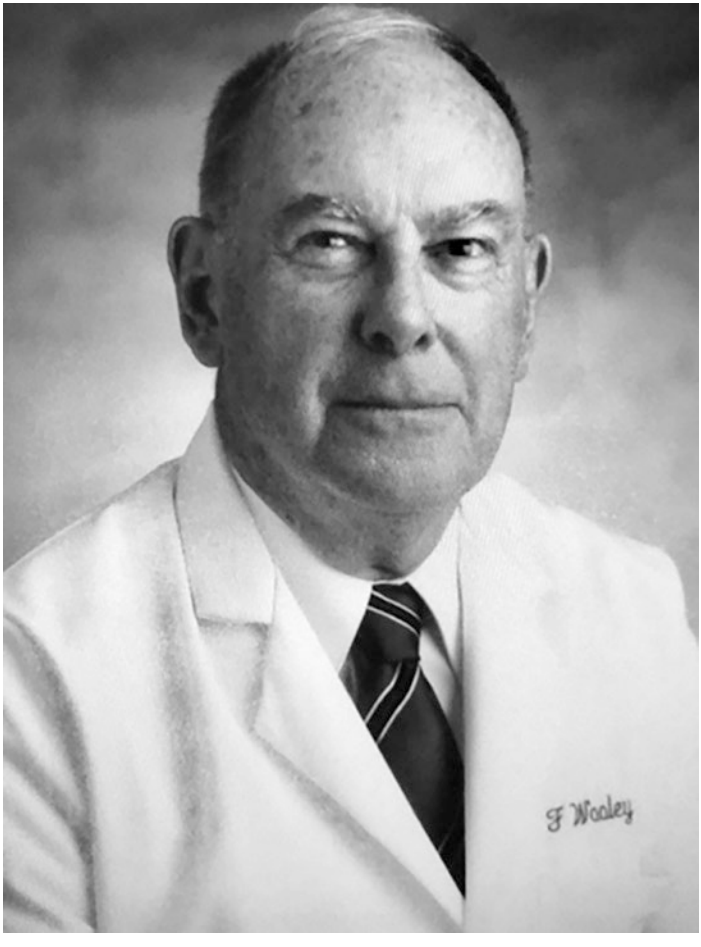

Photo Courtesy Of Ohio State University

Dr. Charles F. Wooley
A Willing, Imperturbable, and Socratic Mentor

[1] Often incorrectly attributed to Mark Twain.

Dr. Wooley was my mentor at Ohio State and a personal hero. His quiet demeanor at the bedside, his rapport with patients, his skill in the physical exam, and thoughtful consideration of the patient's illness motivated me to emulate his example and be my best as a student. He supported my research and reviewed and criticized my papers, which often had as many red lines from his comments as my typed report. Whenever I wanted to record a patient's heart sounds, he provided assess to the phonocardiography lab. Later in my career, he continued to advise and support my activities. Dr. Wooley was a mentor, a master in medicine so impactful on a doctor's career, he could inspire for a professional lifetime.

Dr. Wooley graduated from Providence College in 1950, received his M.D. from the New York Medical College in 1954. He served his internship and residency at The Ohio State University Hospitals, and then attended the US Navy's School of Aviation Medicine, Pensacola, FL. He served as a Naval Aviation Flight Surgeon with U.S. Navy Early Warning Squadrons in Patuxent River, MD; Argentna, Newfoundland, Canada; and as Senior Medical Officer, Marine Air Group 32, Beaufort, SC, returning to Columbus in 1958 where he completed medical residency and a cardiology fellowship at Ohio State in 1963. Dr. Wooley was a faculty member in the Department of Internal Medicine from 1961, and assumed Emeritus status in 1992. During his career, Dr. Wooley was a dedicated teacher of thousands of medical students, striving to impart not only medical knowledge, but also a keen sense of personal and social responsibility, the knowledge to recognize our collective and individual obligations to improve our world while keeping the highest ethical standards. He was willing, patient, and Socratic mentor to many who sought to raise their level of medical knowledge and their practice of medicine. Dr. Wooley was known to many students, interns, residents, and colleagues as a demanding perfectionist who was uniquely creative and rigorously analytical.

Issues Addressed in This Chapter

- A welcoming office staff fosters good communication.

- Develop rapport with your patients.
- If you are delayed more than 30 minutes, ask your staff to inform your patient how long the wait will be.
- Listen to your patient's complete story.
- Encourage your patient to bring written questions.
- When interrupted by staff or a call, before going on review what your patient has told you.
- Urge your patient to bring a family member or friend to accompany them.
- Before your patient leaves the consultation, be sure they understand and are in agreement with your recommendations.
- Be open to questions about cost and other social issues as they affect care.
- Your patients should always leave your office with written instructions.
- Social media—manners, rules, and advice for the digital age.

Study Guide

1. What for the prerequisites for a good doctor-patient relationship?
2. List ways you can make a good first impression.
3. What is the significance of "Why is the patient here?"
4. What is a good way to express empathy with the patient?
5. The clinical case of Martha W. describes a breakdown of the doctor-patient relationship in the office. List all the office and physician deficiencies, blunders, and omissions that Martha experienced.
6. How do you keep to a schedule and stay on time?
7. What can you do to ensure the history is complete?
8. To complete a physical, you have to examine a naked patient—when should you request a chaperone? How do you deal with the following: You think a chaperone is important. The patient believes it is unnecessary?
9. When using social media, what are safe and appropriate ways you can communicate by Tweeting or Snapchat?

10. Can you text or receive texts with colleagues and nurses about test results or patient care issues? If yes, are there any limitations or rules?
11. When you participate in dating sites or public forms, what are the precautions or safeguards you should consider?

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Chapter 8
A Challenging Experience: Inpatient Care

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> *The patient is neither a disease to be discussed, nor a showcase of pathologic interest, nor a dispassionate bystander. He is a sick person in the alien environment of the hospital, disturbed by his illness and involved in it at least as much as the doctors. He is anxious to know what is happening, entitled to find out, and generally able to make helpful contributions to all aspects of his clinical management.*
>
> Alvan R. Feinstein 1967 [1]

The hospital is the sacred, venerated, temple of medicine; a meticulous, organized, scientific wonder, an information technology phenomenon, and a hazardous, treacherous, habitation where patients can die of their disease, a hospital-acquired infection, or an accident. Yet almost all leave in better health, some cured, or holding a new baby, and many well on the road to recovery. Often appreciative patients are amazed at the empathetic, tender care they receive. Fortunately, the bill will not come for weeks, as if to allow the former patient to recover from their life-threatening illness before inflicting them with an economic shock.

We have never lost our excitement and fascination with the hospital. This is how our first author describes his initial visit to a hospital.

"My father suffered a heart attack in 1958, and I was allowed to visit with him. I marveled at the ECG machine recording his heart tracing and, to my teenaged mind, diagnosing his disease. The highly polished tiled floors and sanitized walls were immaculate and almost gleamed. The nurses in starched white dresses seemed saintly in their impossibly intricate hats, and the doctors in flowing white coats with suits and ties left no doubt in my mind they conversed directly with some god of health. In 1958, the hospital and medicine had little to offer a patient with a heart attack. Still, I remember the tender care and the mystery, uncertainty, and alien nature of what seemed a sacred place, one where the nurses and doctors shared very little information with my father or our family."

Considering the Patient First

A lot has changed. Obviously, the science and technology, our ability to diagnose, operate, or treat has improved at quantum speeds. The nurses no longer wear saintly uniforms and are dressed in scrubs of various colors or with interesting designs or animal figures. The doctors no longer wear suits and ties under their white coats. The charts, medical records, even the imaging studies are instantly available in the hospital, office, or personal computer on secured applications. One no longer has to hunt down charts or visit radiology or cardiology to view studies. But have we improved our interactions with patients? Do we still consider our patient's health our first consideration? Just as importantly, in a period of increasing delineation of specialties, do we consider the whole person when we care for our patients?

Sir Robert Platt, Professor of Medicine at the University of Manchester, in the 1963 Linacre Lecture on Reflections on Medicine and Humanism, commented, "There is a side to human behavior in health and disease which is not a thing of the intellect, which is irrational and emotional but important. It is the mainspring of most of what we do and a great deal of what we think, but is in danger of being neglected by clinical science…How often, indeed, do we physicians omit to inquire about the basic facts of happiness and unhappiness in our patients' lives. Yet all this is just as much the living fabric of medicine as biochemistry and applied physiology" [2].

The Emergency Department

The hospital is a small city and each treating group—nurses, administrators, technicians, and doctors—is a team where every member is critical to the patient's successful outcome.

This is especially true in the emergency department (ED). The physician is one of the leaders of that team. Working in the ED, you will likely feel a responsibility to see patients promptly and manage them efficiently. While it directly affects your ability to care for your patient, ensuring the smooth navigation of the waiting room, the ED, and transport to the lab or radiology is a function of hospital administrative and nursing policies and procedures. Sometimes these policies and procedures do not function in the best interest of our individual patients. Although our responsibility is to place the welfare of our patients first, as a member of the team you must function within those constraints. This tradeoff must always be on your mind when you practice medicine.

Unlike the other case studies, the following experience is that of a fictional patient. However, this story is illustrative of the problems patients encounter when admitted through an emergency department (ED).

Barbara M. is a 68-year-old woman admitted to the hospital through the ED with abdominal pain. She had experienced the pain off and on for several days. It is crampy, severe—she rates it 7/10—epigastric in location with radiation to her back. She vomited several times and experienced no diarrhea or constipation. Barbara, like many patients, waited until late in the day to come to the ED hoping her symptoms would resolve. She reluctantly came in as night approached, the busiest time of day.

She waited 45 minutes for the ED physician to evaluate her. Her risk factors included hypertension and smoking for 10 years, but she quit 15 years before being seen. On exam, her BP was 112/68, HR 105, T 37.7C, RR 24. She was uncomfortable, pale, cool, and sweaty. The exam revealed a diffusely tender abdomen and diminished bowel sounds.

The ED physician ordered a series of laboratory studies and an abdominal CT scan. The results were inconclusive as to an exact diagnosis but did show an increase in the white cell count and the scan suggested either an ileus or a partial bowel obstruction. Barbara waited 6 hours while studies were completed and before the ED physician requested a

surgical consult. The surgeon arrived 2 hours later. While surgeons are very responsive to acute emergencies, when the ED physician does not insist on an immediate response, delays may ensue. For non-emergency conditions a patient may wait until the next day, on-call physician availability, the office patients are seen, or the surgical cases completed. We are not judging, just informing the reader the realities of how medicine is practiced.

Barbara waited in the ED a total of over 8 hours before her surgical exam. The surgeon recommended inpatient observation with a decompression tube in place for the following 24 hours and started her on IV fluids. Overnight her temperature spiked to 38.3C and the hospitalist requested an infectious disease consult. Because of the temperature and no change in her signs or symptoms the surgeon recommended continued observation, and Barbara underwent further laboratory and imaging studies.

By the end of 24 hours, three physicians and each of their mid-level practitioners (PAs) had examined her: a total of six people rounding on her, prodding her, and asking questions. She still felt very ill, and of course she continued to be NPO. The hospitalist consulted a gastroenterologist on the second day, and because of a slightly abnormal ECG a blood troponin was ordered. The hospitalist requested the cardiology service evaluate her when he noted it to be elevated.

By this time a total of five physicians and five mid-levels had taken the same history, repeated the same exam of her exquisitely tender belly, and ordered lab tests, many in duplicate. The family did not quite know how to answer the doctors' questions, their anxiety levels had increased, and Barbara continued to suffer. In the hospital inpatient service, Barbara responded to GI suction, her fever resolved, and her extensive cardiac testing did not reveal any underlying cardiac disease. After a 4-day hospitalization, the hospitalist discharged her home with a presumptive diagnosis of partial small bowel obstruction to be followed closely by her surgeon.

This example is complicated but what your patients may experience. We offer no easy answers about how to deal with the problems of what may be excessive consultations, lab tests, and radiology exams. We can address how bedside manners, behavior with patients, family, hospital personnel, colleagues, and good communication skills can refine and enhance your patient's experience, soothe their worry and angst, and promote a faster recovery.

Many patients like Barbara enter the hospital through the ED; many more are seen, evaluated, and sent home. Patients are ill, patients and families are anxious, and their physician has to decide in a relatively short period of time and with limited tests whether to admit to the hospital or discharge them home. It is challenging and exciting. Despite experienced paramedics and nurses conducting triage, and onsite medical fellows in the ED, an ordeal remains for many patients upset and traumatized by their experience. Those working in the ED must examine the issues involved in caring for anxious, ill patients and contemplate ways to comfort the patient while promptly and thoroughly completing the medical evaluation. It is not just about a correct diagnosis; it is also about relief of suffering.

Anyone who presents to the ED has the right, by law, to a medical evaluation. If the patient has an emergency medical condition, the hospital is required "To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or, with respect to an emergency medical condition… [such as] a pregnant woman who is having contractions, to deliver (including the placenta)" [3].

One result of this policy in the USA, where many do not have health insurance, is a crowded ED and prolonged waiting time. There are of course many reasons patients have to wait in the ED—flu epidemics, short staffing, and a surge of ill patients either without a primary care doctor or with a perceived need for medical care after hours—but

waiting for medical care is exhausting, onerous, debilitating, and can contribute to abysmal patient care and disappointing outcomes.

Roger M., a 64-year-old physician, developed chest pain while on vacation playing tennis. Concerned the pain might be due to cardiac ischemia, he asked his partner to drive him to the nearest hospital, a major cardiac center in a southern city. The hospital advertised its "state-of-the-art" cardiovascular center on a large billboard stating they had just added a 40 million dollar addition.

In the ED, despite telling the clerk his concern about his heart, she instructed him to complete his insurance forms before he could be evaluated. Instructed to proceed to the waiting room, he happened to pass by a nurse. He told her he was having chest pain. She again directed him to the waiting room. Thirty minutes later, a transporter wheeled him to an examining room. It took 2 hours until Dr. M. gained access to the catheterization laboratory.

By law, emergencies threatening life or loss of function must be seen immediately, that is, before filling out insurance forms. Yet, when Roger M. later wrote a letter to inform the hospital and doctors of his treatment, they did not apologize or indicate in any way they would change their policies or protocols.

Although this is an isolated anecdote, for a long time this was normal ED behavior. Concerned doctors, knowing how important time delay is to saving heart muscle and working through their professional organization, the American College of Cardiology (ACC), now require heart centers to be certified. Part of the certification process is to document that patients with chest pain reach the catheterization laboratory within 90 minutes of the onset of the pain. The result is a remarkable achievement that has saved lives. It also demonstrates that the patient's doctor *can* make a difference. It is critical to keep in mind that doctors worked through the ACC to effect this change in ED procedure. The change did not come about on an ad hoc basis.

If you identify a *systemic* problem, you must work through the *system* to get it corrected. Osler offered great advice that stands the test of time: "You cannot afford to stand aloof from your professional colleagues in any place. Join their associations, mingle in their meetings, giving of the best of your talents, gathering here, scattering there; but everywhere showing that you are at all times faithful students, as willing to teach as be taught" [4]. This applies particularly well to identifying and fixing issues affecting patient care that encompass medicine, administration, and nursing.

The physician can make a difference for his particular patient despite the insufferable and seemingly unalterable bureaucratic messes that at times plague smooth ED functioning.

Peggy K. is the 32-year-old mother of two, five-year-old Max and his two-year-old sister Zoey. Zoey developed a cough, temperature of 38.8C, was weak, pale, and listless. Peggy called her pediatrician's office. The on-call PA told her a febrile illness seemed to be prevalent in the community, but Peggy should go the ED and have the baby evaluated. When she arrived, she found the ED staff did not expect her. The PA had not called to let them know about Zoey.

The triage nurse assessed Zoey and sent the family to the waiting room. There, surrounded by sick and uncomfortable children and her child's cough worsening, they waited 90 minutes before being escorted to an exam room. After an evaluation by a pleasant, kind nurse and physician, she waited another 3 hours for the initial laboratory studies and X-rays to return. Peggy and Zoey were exhausted, apprehensive, and Peggy became fearful that Zoey was seriously ill. During this entire time no one attended to their comfort, no one informed them how long the wait would be or the purpose of the laboratory tests. After 5 hours of isolation in unfamiliar, uncomfortable, and even disturbing surroundings, Zoey was diagnosed with mild bronchiolitis and discharged home to follow up with her pediatrician.

If you are confronted with this situation, how could you or your team provide comfort, relief, and reassurance for Peggy and Zoey? First, whenever you or your staff refer a patient to the ED, you need to let your patient know you will call and alert the ED of their pending arrival. Then you must call and tell the ED physician or PA about your patient's pertinent medical history and your concerns. There are several advantages to this approach: If the ED is on bypass (they are so busy they can only see emergencies or the hospital is full and can only accept severe emergencies), you might redirect your patient to another facility. If the ED is informed, the triage nurse and ED physician will have some medical history to make their job a little easier. Hopefully you are in a practice where an electronic medical chart is available to you on your home computer or ipad. It is comforting to your patient when they arrive that the ED knows their physician called.

Common consideration requires that someone on the ED staff checks in on the patient from time to time, if for no reason other than to reassure them they have not been forgotten. It is also important to check to make certain the patient's condition has not changed since the first evaluation. Someone responsible should check with the triage staff to give waiting patients an indication of how long they will have to wait. As we have pointed out before, almost every other consumer-oriented business makes a real effort to keep their customers in the loop, aware of how long the wait will be, and what are the factors contributing to delays. Such consideration is sympathetic, reassuring, and just good manners. We have noted that businesses frequently use a beeper or text patrons, a process we feel would work in the ED. The best institutions have a patient advocate who roams the ED waiting and exam rooms, checking on patients, making sure they are comfortable and keeping them updated about the status of their visit. If your hospital has patient advocates, work with them; keep them informed about your patients, and listen to their concerns and suggestions for patient care.

Henry R. is an 83-year-old man with a history of coronary artery disease, coronary bypass surgery, and congestive heart failure. Henry went to the ED with increasing shortness of breath, orthopnea, and paroxysmal nocturnal dyspnea. It took 6 hours for Henry to be seen by the ED physician and have the necessary laboratory studies to make a decision about admitting him to the cardiac unit. While he waited with his wife, Henry received oxygen and an intravenous diuretic. Admission policy also required a cardiac team assessment and orders. It took another 4 hours for the cardiology PA and cardiologist to complete their evaluation. During this time, Henry lay on a stretcher, had not been fed, and required trips to the bathroom. In short, he was just "plain uncomfortable and a bit out of sorts."

This is not an uncommon problem. Often the ED staff, once the assessment is completed but before the patient is actually moved to an in-hospital unit, feel they no longer have a responsibility for the patient's care. There are many excuses: the admitting team is busy, the room is not cleaned, or transportation is not available. However, there is no *good* excuse. This is a most difficult time for a sick patient, and the ED physicians or admitting physicians should expedite their patients' admission to the safe, secure, and caring nursing service on the hospital floor.

Debbie P. is a 73-year-old widow who experienced epigastric pain. She was sure the pain was due to indigestion, but it was very uncomfortable and kept recurring, sometimes associated with anxiety, sometimes during exercise. The severity of the pain and apprehension about the significance of the symptom resulted in Debbie going to the ED. The ED functioned quickly and efficiently. She was evaluated with a history, seen by a physician, received an ECG and laboratory studies. She was told the pain could be due to gastroesophageal reflux, but the ED physician worried the pain could also be due to heart disease. He recommended a stress test after discharge from the ED.

Her personal physician scheduled the test to be completed 3 weeks later. Debbie progressed to a major anterior infarction 10 days before the test date.

A failure of the ED physician to schedule a test for a potentially life-threatening disorder in an urgent and timely manner and the internist's insensitivity to the serious nature of the symptoms resulted in an unwarranted complacency about timing for her stress test. Doctors' responsibilities to their patients do not end with a "recommendation" in a system as complex as our healthcare system. The doctor is accountable for ensuring the patient has an appointment for the necessary referral or test in a time appropriate for the level of concern. Communication in today's world of texting and EMRs is easier than ever. There is no excuse for a lack of communication. Good medical care requires it. Exemplary medical manners require placing consideration for the patient first and foremost. This means concern for their time, attention to their physical and medical needs, and compulsivity to ensure they complete the medical care plan.

The Cost of Caring

There is one other matter we would like to bring to the reader's attention—the cost of the ED visit. When we entered medicine, patients could go to the ED and be evaluated by the physician for a nominal cost. This meant patients with limited means had relatively easy access to the ED. The majority of ED patients just want to be reassured they do not have a serious illness. But with the advances in technology and our magnificent medical building complexes, an ED visit can be very expensive, even if the patient has insurance. Quality bedside medical care always requires ordering only those tests that will make a difference to the patient's care. This is especially true in the ED. An exorbitant cost may prohibit the patient from returning to the ED when a real need arises.

To achieve the goal of cost awareness, we suggest several approaches. CT, MRI, and ultrasound scans are amazing, but they do not replace a careful and thorough physical exam. While not as comprehensive, it can often help with a diagnosis and prevent more expensive testing. Furthermore, when competent doctors manage to reproduce their patients' pain, or hears or feels or even smells the source of a patient's concerns, the patient is reassured that the doctor has paid close attention to their story. Sometimes expensive tests are very helpful but not urgent. In these cases, the patient can be referred to a lower cost alternative such as an outpatient-imaging center. Finally, talk about the cost of studies with your patient and provide alternatives, if possible. As we discussed in the chapter on professionalism, you must consider your whole patient: their health and happiness. The cost of their care is part of that equation.

The Hospital Inpatient Service

A well-functioning office runs smoothly, the usual patient is not very ill, the care team is small, and nearly all the clinical challenges experienced physicians face are routine. This is certainly not true in the hospital. For a patient requiring inpatient services, the change in complexity from outpatient to inpatient is not unlike exiting your family SUV and slipping into the cockpit of a BMW F1 race car. Our most told stories, those relating our most intense and exciting moments in medicine, happened almost exclusively on the inpatient service, in the OR, and in the ICUs. We expect that will be true for many of you.

In the hospital, good communication skills are a critical element of patient care. This includes communication with maintenance and housekeeping, pharmacy, physical and occupational therapy, nursing, administration, admissions, discharge planning, business office, social services, pathology, radiology, all the medical services, and most impor-

tantly the patients. There are specialists in the hospital to ensure every surgical tray has all the correct instruments for each surgical procedure; housekeeping frequently has to rapidly clean a room so an ED patient can come to the floor. These are just some examples. These hospital workers are not invisible people. As the leader of the healthcare team, it is important to treat everyone in the hospital in a manner to show they are appreciated, and they are saving the same lives you are. This will result in better patient care. Your attitude makes a difference.

If this is the first time you are in a hospital, other than as a visiting friend or relative, you probably do not know how the nursing staff is organized. At the heart of hospital care is nursing. Most staff contribute here and there — the physicians spend comparatively little time with the patient — but the nurses are a constant. They monitor patients 24/7, observe their illness, discuss their concerns, meet with their families, and attend to the patient's every need. Outstanding bedside care requires the attending physicians, when they visit the floor, to discuss their patients with the bedside nurse. We loved the old movies where the nurse in a starched white uniform stood at attention at the bedside whenever the physician was in attendance. Yes, that is exactly how nurses behaved when we started out in practice, but now nurses have too many responsibilities, and work too hard to follow previous meaningless formalities demanded by hierarchal medicine. They can no longer instantly stop and be available to round with the doctor. One must read the nurses' notes, then wait for the nurse to be free or leave a message to call. It is rare for the nurse to not have information or a comment helpful to the patient's care.

Ask your patient about their care and communicate their concerns to the nursing staff leader. Occasionally conflicts arise and you or your patient will feel the nursing or physician care could be better. Discuss those concerns with the charge nurse in the privacy of her office. Also, if you are new on the floor or in the hospital as a student or a physician, make an effort to introduce yourself to the charge

nurse and ask if she has any advice that will help you care for patients on her floor. In the following case studies, we discuss some of these issues.

Case Studies

Dr. B. is an extremely conscientious physician who cares deeply for his patients. He is also a lay minister and active on many of the hospital committees to improve patient care. One morning after rounds, while at the nurse's station, he asked his patient's nurse why the daily weights he ordered were not charted. Before she could answer, he scolded her performance in front of other nurses and medical staff. The nurse, an outstanding and highly respected staff member, when questioned about the incident, explained that the patient had refused to be weighed. Nevertheless, she defended Dr. B's behavior, commenting on how much he cares about his patients. Later at a hospital committee meeting, Dr. B. was questioned about his public behavior. Chagrinned and embarrassed, he had not previously appreciated how inappropriately he could behave.

This sort of incident is not uncommon. Many otherwise considerate and caring physicians will react aggressively to both unavoidable failures to carry out their orders in a timely fashion or to deliberate passive aggressive behavior, which does occur. However, no matter the incitement, reactive behavior is never appropriate and always carries the possibility of escalating a minor misunderstanding to a major incident. Although many members of the staff who react in this way may believe they are solving what they see as an institutional, systemic, or individual problem on the spot, their behavior is both hurtful and harmful—hurtful not only to the individual, but also a public embarrassment to their colleagues and harmful in that it demonstrates a lack of respect for the healthcare team members and their colleagues.

Inevitably, some families and patients will question the quality of care they receive. We believe the best medical

manners in such a situation requires proposing a discussion of any quality of care issues with a nursing supervisor in the privacy of her office and never, ever directly criticizing another member of the healthcare team on the floor or under any circumstances in the presence of staff or patients.

Dr. C. is a urologist who specializes in robotic surgery. He feels he is especially meticulous and vigilant concerning every aspect of his patient's care and recovery. This behavior results in a judgmental demeanor toward the nursing staff in the OR, recovery room, and the floor. He does not hesitate to express his disapproval in front of the patient, family, staff, or colleagues. As a result, nurses do not want to care for his patients. In the OR, recovery, and floor, he is assigned the nurse with the least seniority or who pulls the short straw. When he calls to ask the nurses to meet him at the bedside during his rounds, they allege to be on break, in the bathroom, or off the floor. Manners matter, and you want the whole team working to provide good care for your patient. So be considerate, be respectful, and be kind.

Communication on the Hospital Floor

> *In the case of illness, one's confinement, one's hopes and one's fears, what one hears, or believes, one's physician, his behavior, are all coalesced in a single picture or drama.*
>
> Oliver Sacks, Awakenings, 1973

Communication is a key feature of quality bedside care, and communicating effectively requires good medical manners. There are four ways to communicate on the inpatient service: direct person-to-person communication, written communication on the EMR chart, texting/email communication, and by telephone. Each has an important role in patient care, and each has an etiquette, rules of conduct, or courtesy that helps insure the effectiveness and value of the message.

The most valuable and effective communication is direct person to person. This allows for an exchange of ideas,

and you can be sure you deliver your opinion in the most complete and effective way. It is appropriate to interrupt the physician, surgeon, nurse, pharmacist, or administrator in a true emergency, no matter what they are doing. We have had many occasions where we had to talk with a surgeon in the OR or a consultant during a procedure. If your communication does not involve an emergency, be sure to leave a message with the physician or PA, secretary, or answering machine and provide some good time windows when you will be available to answer their return call. Most importantly, give them your cell phone so they can call you directly and do not have to go through staff. It is universally felt to be rude to keep a caller waiting when they are returning your call. As we commented in the chapter on office practice, we discourage any interruption while you are with a patient, but we make an exception when it is a return call involving direct patient care. Never ask staff to place a call for you that requires the person called to wait while you come to the phone. Finally, remember to have significant patient information available, especially date of birth, so the person you call, including your own nurses and staff, can access the EMR.

The progress notes are a critical and key component. They are necessary for communicating with the nurses, paramedical personnel, social service, and other consulting physicians. In the recent past, so many of these notes were unreadable, incomplete, had little helpful information about the patient's condition, and worst of all were signed with an illegible signature so one could not tell who wrote the note. Thankfully the EMR has corrected the legibility if not the content.

Document in the progress note or consult's note the following: what you observe, what you do, your impression and prognostic opinion concerning the patient's illness, results of tests, response to therapy and proposed therapies, your long-term plans, and anticipated discharge or conditions necessary for discharge. This is an essential component of patient care. In the past, the problem-oriented SOAP note helped to

organize the physician's thoughts. Ironically, the PA written note was a vast improvement over the handwritten physician note. They were almost always legible, usually printed, and frequently very complete; sometimes too complete, containing so much extraneous information one could not discern new information and new recommendations. We all expected the EMR to resolve these problems, but sadly that has not been the case. The following are problems and concerns with the current EMR progress note. This is meant to help the reader construct meaningful, decipherable, and instructive progress notes.

Meaningful The subjective part of your note should comment on those signs and symptoms you are monitoring as part of the patient's hospital illness, both positive and negative. If a patient has pneumonia, the note might include if the patient is more short of breath or less compared to the day before, if the cough improved, if the patient is able to eat, and the presence or absence of chills or fever. The physical exam in such a patient should focus on the chest: breath sounds, wheezes, etc. Hopefully, the patient's past medical history, complete review of systems, and complete physical are documented in the original history and physical or consultation note. One does not have to repeat that information. All previous laboratory data and imaging studies do not have to be in every note, just the pertinent older data and new results. Other material is redundant, and the notes are so long that those following the patient will have difficulty identifying the relevant new material concerning the patient's progress.

Many of your patients will have multiple physicians following them. Each progress note should be material to the aspects of the illness of each specialist. Yes, the oncologist's treatment is affecting the heart disease and sepsis, but the oncologist is covering pertinent physical and lab findings for the leukemia, while the cardiologist and infectious disease specialist focus on the daily progress of signs, symptoms, and therapies related to their specialties.

Decipherable Of course one can read every word of an EMR, but when the history and physical and progress notes are jammed with so much cut-and-paste data, the record is overwhelming and as they say "one cannot see the forest for the trees."

Instructive Your notes should not just be a documentation of symptoms and signs but should relate what you think is improving, what is getting worse, your patient's response to therapy, and any contemplated changes. Your contacts with the family should also be documented as well as near term and future tasks and plans. It is never too soon to start discharge planning. A checklist carried forward each day can help in this endeavor.

Who Is in Charge?

Specialty medicine is not without many disadvantages. One must recognize that the results of specialized observation are at best only partial truths and require correlation with facts obtained by consideration of the total patient. The various individual organs or disease processes, each studied by separate specialties and considered individually, are complex parts of a whole entity, the patient. Managing the care of patients with multiple problems brings home, on a daily basis, the truth of the biblical saying "When one member [of the body] suffers, all the members suffer with it" [5].

Recall Barbara M. with her six physicians and six PAs. Every caregiver as well as the patient and the family must be clear about who is in charge. This is not only good bedside manners; it is good patient care. Let us consider another common hospital scenario.

Harry S. is a 78-year-old man who is married and has three children: a daughter and two sons. Harry tripped on a rug in his home and broke his hip. He was referred to the orthopedic surgeon for admission from the ED.

He had a history of hypertension and diabetes. A former smoker, he drank moderate alcohol, and experienced a

myocardial infarction 6 years earlier requiring two drug-eluting coronary stents. In the hospital, Harry became confused and disoriented. The orthopedist requested the hospitalist to manage Harry's medical care; the hospitalist consulted cardiology to clear Harry for surgery; and neurology consulted to assess mental function and rule out a stroke. Harry also suffered from severe anemia, his troponin level was mildly elevated, his blood sugar was 320 mg/dl, and he had abnormal liver function studies. Consults go out to endocrinology, hematology, and gastroenterology.

What approach will make a real difference in Harry's recovery? First, the fractured hip needs repair, and Harry needs to ambulate as soon as possible. Multiple studies show the longer he is kept in bed, the less chance he has to survive his hospitalization; therefore, surgery is the first priority. Each of the specialists needs to consider the tests and treatments required to prepare Harry for surgery, and how the organ system they are asked to assess will fare with different types of anesthesia. Of course, anesthesia also consults on Harry's care and has to approve him for surgery. They all must coordinate their testing to achieve the most rapid and efficient results. They have to clearly describe their plan in the consultation and progress notes, order the tests, discuss their plan and reasoning with the hospitalist and anesthesia, and if there is a disagreement about the treatment plan, they must talk face to face with that specific specialist.

For example, the surgeon would like to fix Harry's hip under general anesthesia but would consider alternatives if necessary. The neurologist wants a brain MRI and the cardiologist wants a lexiscan stress test. Therefore, these specialists have to communicate with each other and share their opinions with the hospitalist. Final decisions, executing the orders, and informing the family should be the responsibility of one physician. In this case, usually the hospitalist, but it could be the cardiologist or neurologist, depending on the severity of the illness associated with their specialty. Everyone must be on board and know who is the responsible individual. Certainly the surgeon must

know so she will understand who is responsible for the final clearance for surgery. The nurses must know so they are aware of whom to ask to resolve any conflicts in scheduling and testing, and who will answer the family's questions. Each of the specialists must know who is ultimately in charge of Harry's management plan so they are informed about whom to communicate with first.

Medical Manners and Working with Patients and Family in the Hospital

Often hospitalized patients are too ill, too confused, or too anxious to really understand what one is trying to communicate. Every time you talk with your patient consider their state of mind and judge how much information can be understood. You must inform your patient and/or their family of the tests you are ordering, why you ordered them, and when they will receive the results. It is helpful if you can let the family know when you plan to round, and if that is not possible obtain a family contact number so you can share important information and answer questions. The hospitalist is in the hospital at all times, so it is easier for the family to communicate with that physician. But remember, if the question concerns a surgical issue, the patient and family will want to hear directly from the surgeon. The same is true if the patient suffered a heart attack—they want to speak with the cardiologist. The hospitalist may be coordinating care but the patient and family will want to hear from each physician caring for the patient.

Caring for the Patient

> *The most common criticism we hear from practitioners with many years experience is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or to put it more bluntly, they are too "scientific" and do not know how to take care of patients* [6].
>
> Francis W Peabody 1927 JAMA

Abraham Verghese, a physician and best-selling author, in a TED talk on patient care, referred to the hospital as the "ihospital," a place where patient care and disease management is completely managed online [the EMR],that is, devoid of significant face-to-face contact with the managing physicians. Patients and families can be lost in this system, and it is absolutely necessary to remember the focus of concern is caring for the whole patient as well as treating their disease. As Claude Bernard, the French physiologist who first used the "scientific method" said, "A physician is by no means physician to living beings in general, not even physician to the human race, but rather, physician to a human individual in certain morbid conditions peculiar to himself and forming what is called his idiosyncrasy" [7].

The Johns Hopkins clinician Philip Tumulty taught "His [the physician] thoughtful management of the total problems of the sick person makes mere treatment of a disease or a symptom seem woefully inadequate. He is inexhaustibly capable of infusing into his patients insight, self-discipline, optimism and courage. Those he cannot make well he comforts. Versed in medical science, he also understands human nature and enjoys working with it. The things he works with are intellectual capacity, unconfined clinical experience, and the perceptive use of his eye, ears, hands, and heart" [8].

Dialogue with the Family

There is a group game in which the players create a picture or story. The first player draws a picture or tells a very brief story in secret to the next player. As the picture or story is passed around, considerable changes occur until by the time it reaches the originator of the story, the narrative or picture has changed considerably.

Something similar happens when multiple physicians and PAs confer with patients and family from their different perspectives. It is saddest and most harmful when the team leader feels hospice is the best choice for the patient

and another member of the physician care team, on occasion less informed, offers a more hopeful outcome. When discussing prognosis, long-term care, rehabilitation, and death, one needs to be sure all are on the same page as the managing physician. It is always wise to discuss discharge planning directly with the managing physician and patient's nurse when the patient is close to discharge. Do not depend on the progress notes, nurse's comments, or social service alone. Some aspects of the care plan can only be properly managed if the lead physician is fully informed. A patient may become confused or even unnerved if multiple comments suggest multiple courses of action. It should be obvious that any advice concerning diet, lifestyle, medications, rehabilitation, and follow-up must be written. This is hospital protocol.

Remember William Osler's words on the duties of a physician:

"We know more and enjoy larger opportunities and with them have greater responsibilities, but could Hippocrates return he would find no change in those essential duties in which he is still our great exemplar. They are four: … facility in the art of diagnosis, …grow in clinical judgment; … conduct the treatment;… and lastly, so to arrange sanitary and hygienic measures that, wherever possible, disease may be prevented" [9].

Considering Abusive and Disruptive Behavior

> *It must be confessed that the practice of medicine among our fellow creatures is often a testy and choleric business.*
>
> William Osler Aequanimitas

Good manners are not just about agreeable behavior and demonstrating respect. As we discussed in previous chapters, good manners and respect for patients and colleagues are not only essential to providing good care [10, 11], but can be considered a moral imperative. The Joint Commission on Accreditation of Hospitals and Healthcare

Organizations (*JCAHO*) is a voluntary, not-for-profit organization that accredits all the member healthcare institutions in the USA. A hospital must be a member of the JCAHO to qualify for Medicare and Medicaid funds. The JCAHO provides onsite inspections of hospitals and outpatient facilities and is responsible for determining if the organization is in compliance with the Medicare standards of quality performance. According to the mission statement, the JCAHO strives to "continuously improve healthcare for the public…" The JCAHO manual runs to thousands of pages of requirements, visits can be announced or unannounced, and should a hospital fail its inspection it can be put on probation and if necessary, operations can be shut down.

In January 2009, the JCAHO issued standards that addressed disruptive and inappropriate behavior in healthcare institutions—behavior that can result in poor medical outcomes. These standards encourage hospitals to adopt a code of conduct to define "acceptable and disruptive and inappropriate behaviors" and "educate all team members—both physician and non-physician staff—on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect [and] include training in basic business etiquette and people skills."

The JCAHO has instructed each hospital to define its own code of good behavior. Unacceptable behavior is addressed more directly, but subjectivity abounds. According to the JCAHO, even an "imperious glance," if interpreted as intimidating, can be grounds for suspension of a doctor.

The attempt to create an enforceable "code of conduct that defines acceptable and disruptive and inappropriate behavior," is a good first step, but vague and indefinite definitions invite inequitable application of the rules. The Joint Commission is attempting to legislate manners without taking on the herculean task of defining all good and bad behavior. Some activities, verbal outbursts and physical

threats, are clear-enough transgressions of civil behavior, but who is to define "uncooperative attitudes during routine activities" or "condescending language or voice intonation," and "impatience." These transgressions are vague and potentially allow each individual to improvise a set of rules for any situation and follow only those they personally invent, perhaps on the spot.

Rather than emphasize punishment for "behavior that adversely affects patient care," by itself a critical event, we would encourage hospitals and healthcare organizations to emphasize the education component of the JCAHO recommendations. Teach staff how to behave properly in a myriad of situations. Adopt the goal of enlightening individuals in how and why the display of respect to each other is so important to self-esteem and skill development as well as patient safety. It has worked for sexual harassment; it can work for manners in the hospital setting.

The practice of good manners should be encouraged. Failure to make the effort to appear agreeable in stressful situations results in churlishness, verbal outbursts, passive aggressive behavior, and plain old rudeness. We all have a moral obligation to be agreeable, and acting boorishly indicates a lack of moral character. More importantly, acting in a manner that appears to indicate respect for others can inspire individuals to actually consider the dignity of others. So rather than emphasizing legislation of interpersonal behavior in the hospital and clinic, we modestly propose education and encouragement of good manners and appropriate behavior in stressful situations. Of course, egregious behavior that "undermines a culture of safety" must be promptly eliminated [12].

Case Study

Dr. J. has staff privileges at the main hospital, Central Regional Medical Center, but admits the majority of his patients to the rural hospital, Western Community Medical Center. One Sunday Dr. J received a message from his answering service

to call Joy Williams, a patient he had known for 15 years. He had been following her closely for several weeks with home BP monitoring and frequent office visits due to her symptoms of intermittent headache, weight loss, and palpitations. But her vital signs were stable every time he saw her in the office.

Joy enjoyed good health until she recently returned to the work force as a public relations vice president for a locally based, national food company. This is how Dr. J. tells the story (dialogue recreated).

"When I returned the page, her husband answered the phone. It was clear he was struggling to control his voice."

"'Joy's not acting right,'" he said.

"What do you mean?" I asked.

"'Well, when we got home from the lake, she said she had a headache. I told her to take a nap, that I would fix dinner. She went into the bedroom, but came out in her nightie and slippers and said she was late for the office.'"

"What then?"

'I took away her car keys, of course.'

"He chuckled, but I knew he was trying to minimize his fear."

"'We had a fight. She cried, went to bed, and then came out 5 minutes later and asked for the dog. She had a weird look in her eyes and kept searching about." Dr. J. paused in his story telling. "'The dog died a year ago.'"

Dr. J continued. "When I saw Joy in the office the previous week, her blood pressure was elevated, so I started her on anti-hypertensives. If she didn't improve or respond to therapy, I would admit her for a workup. I knew if I admitted her without a trial of anti-hypertensives, I would have a tough time justifying it to the insurance company, but doing the work up as an outpatient can be difficult and there are many infinite possibilities for a screw up, especially on the 24-hour urine collection I wanted to order."

"I told her husband we would admit her to Western, and that I would be over as soon as she was admitted. I have all the numbers of the two CRMC hospitals in my cellphone contacts list. I called the admissions desk and told them to

expect her, left some orders, and asked for the nurse to call me when my patient settled into her room. I felt pressed and a little guilty that I had waited. Not that I am excusing my following behavior, just trying to explain it."

"I waited and waited and no call. At 11 I called Mr. Williams back and asked what had happened. He said he was waiting to speak with me at the bedside. That they had gotten settled by eight. Three hours. Why hadn't the nurse called? What about my instructions? Now it would be impossible to complete the urine collection before the next day's MRI. And on top of that, the nurse hadn't even called me with the vital signs. Joy's blood pressure worried me, and now her husband might think I didn't care enough to hustle over to meet him."

"When I got to the hospital I checked the computer. Joy came to the third floor at 7:48. I went directly to her room. She was asleep. I asked Mr. Williams if her condition had changed since he spoke with me, and he said no. Then he told me the nurse had been waiting for my call so I could give her admission orders. Waiting for my call? Admission orders? I had asked her to call me."

"I reassured Mr. Williams that we would start the testing immediately, and then I stormed over to the nurses' station. Of course the nurse, a young woman I think was working for maybe 3 months, they always put the newbies on at night, looked up, smiled and said Good Evening Dr. J."

"Now, I am not proud of what followed. I only offer it as a cautionary tale. I have certainly learned a lesson. At first, I ignored her and picked up Mrs. Williams chart. Her BP was 180/120. I needed to treat that right away. Her pulse was 110, also high. I put down the chart and leaned over the nurse's desk."

"Why didn't you call me like I asked?" I said. Her smile faded, and she suddenly looked a little sick. Even now I feel badly about how I behaved.

"I called the admissions desk and left a message for the admitting nurse to call me." I got louder and louder, and I am sure I looked angry.

"'I didn't get any message from admissions. Mr. Williams said you would be right in, so I didn't call you for orders. The patient just showed up, so I put her to bed.'"

"Oh really. You're saying I didn't leave a message or orders?"

"That was my first mistake. I should have just let it go, chalked it up as a screw-up. After all, they happen every day, and on the grand scale of things, this was not a very important one at that. No one died. Instead I put words in the young woman's mouth. As if to say she was calling me a liar. What was I thinking? That she had made an error and my berating her would prevent any future errors? That if I made her feel badly enough, she would never again make any mistake?"

"Just then the nurse supervisor, Miss Wallace, happened along. She smiled. Looked from me to the nurse and back. Saw my anger and that her nurse was near tears."

'What's the problem?' she asked.

"I explained about my calls. Having to wait. Missing an opportunity. That the nurse was accusing me of practically abandoning my patient."

"I can prove I left a message." I dialed the admissions clerk on the hospital phone, a woman I know by first name. "Cheryl, this is Dr. J. I have Miss Wallace up here. Tell her the message I gave you when I called in the admission."

"'You never called in an admission, Dr. J. Sorry. Your patient just showed up.'"

"Miss Wallace and the nurse must have heard. They're staring daggers at me. Wallace's lips were so tight they looked glued together. She and I have never been friendly, and I could almost hear her complaining to the CEO."

"Now come on. We spoke. It was about 7. You must have come on duty just before."

"'You never spoke with me.'"

"At this point I was getting paranoid. For some crazy reason Wallace organized a campaign to drive me nuts, and it was working. I took a deep breath, trying to figure out what the hell was going on. That's the only thing that saved me from erupting, trying to noodle out the problem. I know Cheryl. She would not lie to me. Something was terribly wrong."

"I'm going to get to the bottom of this tomorrow, I told them. "But for now, just take the orders and see if you can get something done tonight. Again, I couldn't help myself. Sarcasm never works. No one appreciates it as a joke and everyone in hearing distance is insulted when it's meant as a putdown. I was fuming, but I wrote the orders in a steady hand. Miss Wallace told the young nurse to leave and get herself together, that she would deal with the orders, and in fact, she did get the tests going."

"First, as far as Joy was concerned, I put her on meds to bring down her BP, her urine test was positive, and she did have a pheochromocytoma on MRI. The slight delay in diagnosis was nothing compared to trying to get OR time. But we got it done, and Joy Williams is fine."

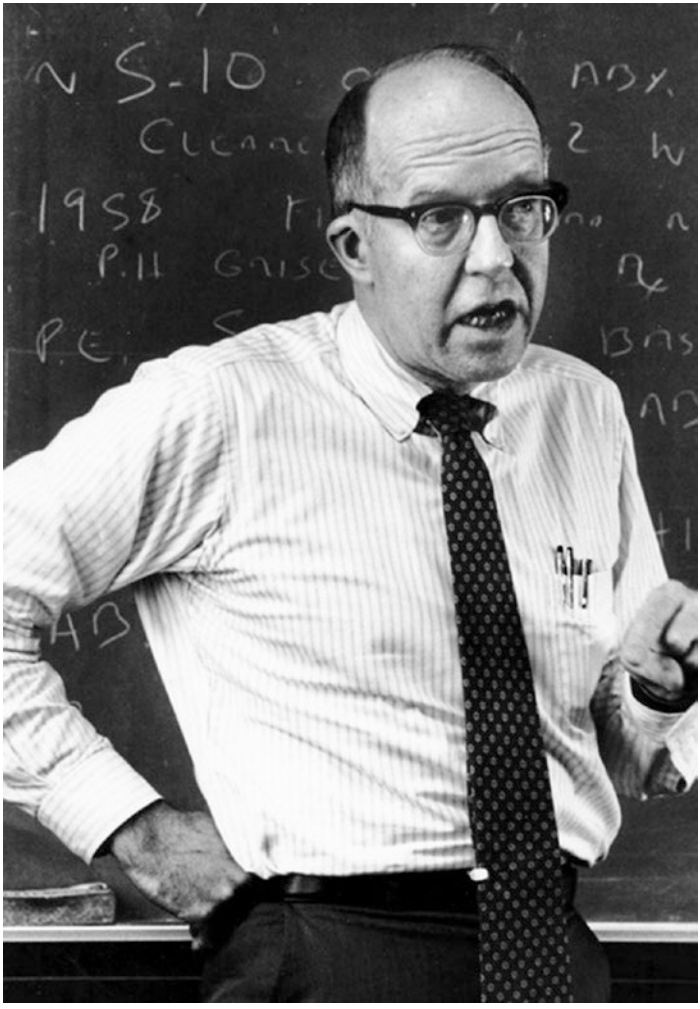
"Marianne Wallace did report me to the CEO, who filed a complaint with the Medical Executive Committee. They asked me to explain my actions. By that time I had figured out what had happened. I checked my cell phone records the next day and discovered I had called the main CRMC hospital admissions clerk rather than Cheryl at Western. The woman I spoke with had taken the message, and as far as I know is still waiting for the Williams family to show. As Cheryl said, I never spoke with her."

"I apologized to the nurse that next day, and she graciously accepted my apology. She excused my boorish behavior and laid it off to the hour and my desire to get started on a treatment plan for my patient. I also apologized to Miss Wallace, and although she frostily accepted my apology, both oral and written, the fact is she reported me."

"This could all have been avoided if I had first assumed that everyone was doing their job as best they could, and some other explanation other than a ridiculous intense desire to obstruct my plans was the cause of the delay. Second, I could have accepted what the nurse said and not responded to it, even if I did not believe her. After all, if she were lying about not receiving my message, how would calling her attention to it change her behavior? And last, losing my temper served no earthly purpose. It did not make me feel better, it made everyone around me feel awful, it slowed down the process of getting my patient cared for, and I could have potentially ruined a young nurse's career. To say nothing of my own."

Dr. J. learned from his boorish behavior, but the lesson was hard won. Many doctors demonstrate rude behavior, and while in this case report the nurses acted appropriately, many healthcare personnel do display passive aggressive behavior and many administrators disrespect both doctors and nurses and rule with an autocratic hand. Sometimes it really is a war out there, and when a battle is occurring whether in the OR, hospital floor, or administrative office, your patient is the battlefield and suffers the most.

In statecraft and in the hospital, diplomacy is always preferable to war. In these situations, a gracious doctor under pressure serves as an excellent example to the healthcare team.



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Thomas Evans Brittingham II
Teacher Par Excellence

TEB, Thomas Evans Brittingham, was a legendary teacher on the medical wards at Vanderbilt Hospital, a man who taught by example and whose commitment to and love of medicine was so infectious that it motivated his pupils to a dedication and devotion to our profession. At the beginning of the medical clerkship, TEB distributed a detailed guide of what was expected of a student.

> The first and greatest responsibility is to obtain a complete and accurate history, perform a complete and accurate physical examination, and to record fully the results of both. One becomes a good physician by first learning how to make detailed and correct observations, then by learning how to make a diagnosis from the observation…and finally by learning how to make the correctly diagnosed illness get better…..It is only by being thorough now (as a student) that you can learn how to be selectively thorough later, i.e. where you can safely take shortcuts….A section called Formulation should be incorporated into each history you write. It entails the preparation of a well-organized concise, a logical discussion based on a thorough knowledge of the patient's symptoms and signs and of the diseases which they signify. …In writing this section one is trying to teach oneself to think and to write clearly. DO NOT under ANY circumstances write a formulation longer than one page, a longer one will simply waste your time and make others less likely to read what you have written [13].

TEB insisted that the student personally review every piece of data that was obtained on a patient and he was legendary at turning up unsuspected data that clinched a diagnosis. A typical example was a case Alan Graber describes in his biography of TEB.

> A third-year student presented the following case. Mr. K entered the hospital for an aorto-femoral graft and is now convalescing from the operation. TEB interrupted and said "I've spent some time with Mr. K would you mind if I told the group what I learned." TEB said the patient's problems began over two years ago when he just didn't feel well. His friends thought he was experiencing a mid-life crisis. At his wife's urging he saw his physician who found a prostate cancer with metastases and the patient underwent usual therapy which included orchiectomy

(castration to reduce the growth of the tumor). The patient continued to feel poorly and depressed. The patient was told:" this is to be expected after a diagnosis of metastatic cancer and having your balls cut off." Then TEB asked the student if he had reviewed all the patient's pathology slides from the prostate cancer admission. And yes, the student had personally reviewed them, he asked what about the testicles. The reply was that there was no pathology report on the testicles and it was felt they were normal tissue since they were removed for therapeutic reasons. TEB smiled and agreed he could not find a pathology report on the testicles in the chart, so he went personally to the pathology department to review their files. There he found a report on the testicles that had been signed off by the chief of pathology and read as normal testicular tissue. Now, he noted if the pathology resident had reviewed the slides he would have felt it would have been exhaustive, but he knew the chief of the department had better things to do than examine normal issue and had probably just signed off on the report. So TEB reviewed the slides himself finding evidence of chronic infection consistent with disseminated histoplasmosis [13].

It was not just an amazing diagnosis, it was his commitment to the patient, to personal involvement, and carefully and completely reviewing the data. I have so many personal examples in my own practice where the written report said one thing and my inspection of the data or image something else. Cliff Cleveland, my chief resident at Vanderbilt [14], wrote about TEB: "The great teachers challenge us to reach deep inside to examine our assumptions. He was the greatest."

Issues Discussed in This Chapter

- Responsibilities to the hospitalized patient in the ED
  - Keep the Patient and Family Informed

    What tests you are ordering and why.
    How long you expect your patient will have to wait for the results.
    Keep your family informed concerning your patient's progress.
    If expensive tests are ordered and not an emergency, inform the patient of less expensive alternatives.

Communicate with your patient at least every 30 minutes to provide a status report.
If follow-up testing or office visit is recommended, let your patient know how urgent the studies are and arrange the testing or appointment if possible.
If you decide to admit your patient from the ED, continue to monitor with 30 minute status reports until transfer.

- Responsibilities to the Patient on the Ward
  - Let the patient and family know what tests are ordered and why and when to expect the result.
  - Inform your patient and family an approximate time you will round.
  - Keep your patient abreast of their progress.
  - Communicate with the healthcare team: nurses, paramedical personnel, social service, and consulting doctors in a regular and timely fashion.
  - Be clear at discharge that all the healthcare providers are on the same page.
  - Be sure there is communication with the follow-up healthcare providers concerning the care plan.
- Polite communication with colleagues is essential.
- One physician, one patient: One physician must have the responsibility for final decisions, executing orders, and informing the family.
- Disruptive and inappropriate behavior in healthcare institutions is not acceptable.

Study Guide

1. Consider the ED visit of Barbara and what could have been done to shorten the time in the ED, relieve patient and family anxieties, and possibly decrease the number of history and physicals and tests she underwent.
2. How would you have treated Peggy and Zoey? What do you feel is the responsibility of the referring doctor or PA and the ED doctor and nursing staff?

3. What is the physician's responsibility if he feels a patient needs a follow-up after discharge to rule out a potentially life-threatening disorder?
4. Is the cost of care a concern for the physician? If you feel it is how do you address that with the patient? If not, justify.
5. Who is in charge of a patient and how do you resolve any confusion?
6. If you believe the patient is not capable of understanding their medical problems or consenting for tests and procedures what is your responsibility?
7. How would you manage Dr. J.'s disruptive and inappropriate behavior?

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Chapter 9
Breaking Bad: Bad News, Unexpected News, and Hope

Barry Silverman and Saul Adler

"I'm afraid there's really very little I can do."

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B. Silverman, S. Adler (eds.), *Manners, Morals, and Medical Care*, https://doi.org/10.1007/978-3-030-60344-1_9

> *In some of us, the ceaseless panorama of suffering tends to dull that fine edge of sympathy with which we started…Against this benumbing influence, we physicians and nurses, the immediate agents of the Trust, have but one enduring corrective—the practice towards patients of the Golden Rule of Humanity as announced by Confucius: What you do not like when done to yourself, do not do to others.*
>
> William Osler Aequanimitas

Hope is one of the most important comforts a physician can bring to a bedside. Your patient care begins with providing hope for recovery, and if recovery or cure is not possible, hope for relief of pain and to make your patient more comfortable. Additionally, you must reassure your patients and their family you will support and be available to them throughout the illness.

Harris and DeAngelis, in their article "The Power of Hope," stress that the physician must participate in a "sincere emotional engagement [with patients and] address the patient's fears" [1]. Patients face their physicians with foreboding and apprehension. If all hope is withdrawn, despair follows.

Most, if not all, medical students enter their training with lofty ideals, intense feelings of empathy, a mission to provide care and alleviate suffering, and a formidable drive to achieve exceptional patient care. In order to fulfill their desire to accomplish these goals, it is imperative for trainees in their early years to know the techniques for delivering unpleasant and unexpected news.

One of the core competencies of the ACGME is communication skill, an essential skill for conferences with patients and families. Delivering bad news, that is news that has the potential to change your patient's life in an instant, is a particularly difficult skill, especially if you have only known your patient for a short period of time and have no or only a limited relationship with the patient or their family. Not knowing what to do or say will frequently result in misunderstandings, false expectations, and resentment. The fears trainees have about delivering tragic news can lead them to seem unsympathetic or even callous [2]. We know from personal experience

that patients and families never forgive a doctor who conveys bad news rudely or abruptly. This chapter is meant to help the trainee the first few times they are called upon to execute this most difficult of tasks.

If the news is grievous and life changing, you may have to deliver it in short bouts, allowing the patient and the family to process the information with each visit before going on to elaborate. Often patients who receive an unexpected and unsettling diagnosis will say that after they heard the word tumor, or cancer, or ICU they were not able to hear anything else. This is true even for patients who receive good news. We have had patients tune us out after hearing "benign." It is as if the following 15 minutes or so of conversation, that often includes the treatment plan or expected length of stay, never happened. Be sure your patient is listening and can say back the information you have given them. When you deliver the news be sensitive, be caring, and be careful not to be callous or rude. Maintain some level of hope, even if it is only the hope that you will be able to keep your patient comfortable or to provide compassionate care.

Breaking bad news requires a number of skills. In addition to actually giving the information in a way your patients and families understand, (for convenience we will use "patients,") you must be able to "read" your patients' emotional state, expectations, knowledge level, and the possible impact of the news. A bit later in this chapter we will make some suggestions on how to respond to their emotional state appropriately, enlist your patient into the decision-making process, give some form of hope when the situation is bleak, make a realistic treatment plan that everyone agrees to, avoid any misunderstanding, particularly about prognosis and above all, do not eliminate all hope.

Implicit biases [3] are unconscious attitudes that shape our behavior and affect decision-making. Because these biases are unconscious and formed by life experiences, they are not readily reversed by introspection. Implicit biases can compromise your relationship with your patient. Do not presume you know how your patients feel. Do not relate a personal

experience to what they are experiencing. Avoid religious metaphors unless you discern they will be helpful. If so, a good idea is to ask if the hospital chaplain can visit with your patient, or even better, have the chaplain accompany you in this conversation [4].

SPIKES is a six-step protocol that works well in delivering bad news to patients and their families [5]. It also serves as a convenient mnemonic for rehearsing what you will say. The following is adapted from the SPIKES paper by Baile et al. and used with permission:

*S*et up the interview. Rehearse what you are about to say out loud. Listen to yourself. Have a colleague or the patient's nurse accompany you to be certain you cover all the needed information, but be sure you are the only spokesperson. You, your colleague, and all the consultants must be in agreement. Arrange for privacy. Turn off your phone. Make sure a family member or friend of the patient's choosing is present. Have a notepad for the patient and tissues at the ready. Sit down. This conveys to your patient you have all the time in the world. It also helps to make eye contact, which is critical. If your patient is comfortable with it, lightly touch their arm or hold their hand, or have a same-sex nurse or colleague do this.

Ask your *P*atient: Start by asking your patients what they know about their illness and what they expect. Use open-ended questions. Observe their body language. Body language can communicate much information, especially when words fail [6].

*I*nformation: You must decide how much information your patients can process. It is often not possible to complete the entire task in one sitting. Some patients want to know the reason for and the result of every test, while others just the bottom line. We had one long-term patient's family tell us they only wanted to hear "good news." Unfortunately, good news was sparse, but we knew we had to find something just so we could communicate on a regular basis. Each day we would tell the family which tests we ordered, but we would offer the results only when they asked for them or if they needed to make a decision.

*K*nowledge-Foreshadow and impart: After the preliminary questions, foreshadow what you are about to say; "I have some unexpected news…" or "The test results indicate we will have to adjust our treatment…" Use nontechnical words. Do not go into unwelcome detail. Do not over prognosticate. No one knows the exact future of anyone. Avoid bluntness. Never, ever use the phrase "At least you…" Many patients will tune out after they hear words like untreatable, cancer, severe, sadly, bad news. Wait for them to regain composure and focus. If necessary, you can ask for permission to tell their accompanier limited details.

*E*mpathize: Sit close to your patient. Lean forward. Touch your patient's arm if they are amenable to this and signify with a nod that you understand their response. If they freeze, ask them what they are feeling. Respond by validating their emotions. It can be helpful to your patient to "echo back" to them what they have just said to you. This validates whatever they are feeling. Offer a tissue if needed. Empathize. "I am feeling that too," or "We were all hoping for a better result." Or "I wish I had better news." Remember to reinforce you are still on their team. They have not disappointed you. You will always be there for them. Ask your patient if they have any specific questions, fears, or concerns. Be sure to acknowledge them as appropriate, whatever they are, and address each one by responding directly or offering a plan. Do not blow off any fear or question, as the patient may interpret this as the worst-case scenario. Never say "I know how you feel." Even if you have been in exactly the same situation, you cannot know how someone else feels.

*S*trategize treatment or comforting measures. Make certain your patient understands what you have told them. Ask them to "say back" to you what they heard. Be certain you tell them you will revisit in an appropriate time.

Although it is of little consolation, the two events uniting all of us on this planet are birth and death. This is something trainees might not keep in mind. Before you speak to your patient, consider how you might want to hear the same news when it is your time to share this universal experience. As usual, the Bard expressed it very well: "We are such stuff

as dreams are made of: and our little life is rounded with a sleep" [7]. Your patient will feel isolated and abandoned and fearful. Allay those fears.

How you deliver unexpected news will influence your patient's expectancies concerning the illness, and this, in turn, will affect your patient's decision to cooperate with your treatment plan. A sad demeanor or foreshadowing incorrectly by using words to indicate pessimism may leave your patient feeling helpless and under the impression that treatment is futile.

Different patients will respond to the same news in different ways: anger, denial, depression, anxiety. Their own implicit biases will affect their responses, and their interpretation or understanding of any facts you may give them will be shaded to a mild or greater degree by their beliefs and the manner in which you deliver the message. At times, their "say back" to you will have little relationship to what you have told them. Therefore, it is very important to have them repeat any diagnosis or treatment plan you have given them to be certain they are in full understanding. Do not withhold the truth or offer false hope. Never, ever lie in any way. Eventually your patients will discover what it is you did not want to tell them, and from that point on, they will not trust anything you say.

It has been our experience that a realistic, hopeful assessment of your patient's illness and your commitment to never abandon your patient throughout their illness will result in a better social and emotional adjustment. Even offering only optimism about your ability to reduce or eliminate pain and suffering, or mitigate the side effects of therapy will help your patients manage the debilitating aspects of their disease. The following case studies will provide some suggestions to offer you support and knowledge for those occasions where you have to deliver discouraging or unexpected news.

Susan C. was a 56-year-old nurse diagnosed with advanced pancreatic cancer, a disease that carries a 95% 5-year mor-

tality. Her doctors advised her that surgery would provide the best chance for her survival. She elected to travel to an international cancer center for the procedure, where the specialist cancer surgeon, after reevaluating her prognosis, recommended she not proceed with surgery. He explained he would not be able to remove the cancer. He offered no further recommendations or any treatment plan. He advised her to return home and see what developed. Susan did not believe death from the cancer was inevitable. "I wasn't about to let a group of malignant cells decide what was going to happen," she said.

Upon her return home, she met with her oncologist. He advised her to treat the cancer like a chronic disease, not a fatal one, and he promised to try every reasonable treatment available, short of surgery. After chemotherapy and radiation, Susan experienced a long-term survival. The referral surgeon's lack of all compassion and what was essentially his withdrawal of care devastated Susan and her family. One might describe Susan's reaction to his consultation as denial, anger, or depression—even irrational or quixotic to feel hope when struggling against a disease with a 95% mortality. Susan had what is called a generalized hope, a sense that maybe something helpful and beneficial could be done. Her oncologist helped direct that hope to a specific one, a treatment that might not be curative but would result in a prolongation of her life and a chance to live that life in a meaningful way. Most importantly, he validated her feelings and let her know that whatever happened, he would support her.

Abede H. was an Ethiopian male with angina, diabetes, coronary artery disease, heart failure, and end-stage renal disease for which he required chronic dialysis. His doctors had ruled out coronary artery surgery as being of little benefit due to the severity of his disease, and he required frequent admissions for heart failure. Abede was a very outgoing, courteous, and good-natured man with a wonderfully supportive and

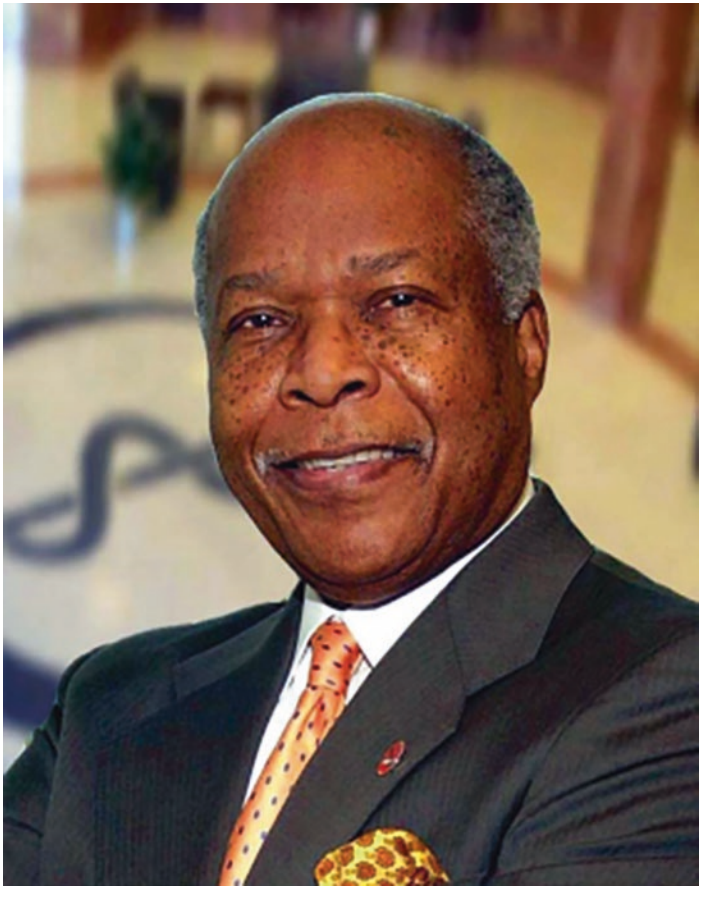
loving wife and a great desire to continue living. He and his wife did not like his emergency admissions to the university hospital where the physicians caring for him reinforced the grim nature of his disease and his very poor prognosis. In contrast, the more experienced senior cardiologist at his community hospital supported and reassured him, promising that he would improve with each hospitalization. After several years of this cycle, Abede required admission due to refractory heart failure. He did not respond to supportive measures. When the intensive care physicians explained his hopeless condition, he and his wife became angry and refused to allow care to be withdrawn. The senior cardiologist had always reassured them this was a treatable disease, they explained, and that he would improve. This unrealistic and untruthful assessment of his illness gave false hope to both Abede and his wife.

In this situation, the hope from his physician misled Abede and his family. His cardiologist could have explained the following—that Abede's heart failure could be managed but would recur, that good medical management could control his diabetes and improve his blood pressure, and working as a team they could prolong his life but he would not be cured of his disease. At some point, he would not respond to their treatments, and he would not survive a hospital admission. While it is not likely a patient with such a complicated condition is likely to understand the unrelenting nature of his disease, most patients will understand the broad implications. But at the same time as preparing his patient for the inevitable, the doctor can offer the hope of having some effect on the course of his patient's condition. Providing your patient with an honest, realistic, and truthful assessment of their illness and prognosis is often very difficult without causing harm. But an inappropriately positive attitude and unrealistic offering of hope is as hurtful and unhealthy as a blunt uncompromising outlook.

Always make sure you and your colleagues are on the same page. The following is an all-too-common example of one physician delivering bad news devastating to the patient only to have another disagree. We had one pediatric patient with severe lung disease. One attending, covering for another who was away at a conference, told the family the child would die. When the admitting physician returned to care for the infant, he corrected the family's misimpression, and after a rather long hospital stay, the baby did quite well. She was discharged off all medication and off supplemental oxygen. When the father, several years later, ran for public office, he made the point that he was from a "family of fighters." As evidence, he displayed his 8-year-old daughter to the news cameras and said, "The doctors told us she would die, but here she is. She's a fighter, too."

The science of medicine is ever changing, but the art of medicine remains constant because human nature does not change. Patients bring fear, anxiety, and self-pity into the exam room and the consultation room. As their physician, it is our responsibility to calm their fears as best we can while at the same time be forthright and honest about what they have to face. Hope and optimism about some aspect of your patient's care may not alter the medical outcome, but can assist your patient in achieving some degree of comfort and acceptance [8–10]. This is true for psychiatric disorders as well as physical illness.

Delivering bad news incorrectly may seem like a trivial thing compared to a missed diagnosis or a poor surgical outcome. However, once words are exchanged they can never be taken back. You can correct a missed diagnosis with additional studies and observation, and with skill and good timing you can correct a poor surgical outcome, but once hurtful or misunderstood words are spoken, they live forever.



Louis Wade Sullivan, M.D.

Clinician, Scientist, Educator, National and World Leader in Public Health

Your first impression of Dr. Sullivan is his warm smile, attractive personality, and the sincere straightforward interest he has in what you have to say. Louis Wade Sullivan was born on November 3, 1933, in Atlanta, Georgia, but grew up

in rural Blakely, Georgia, where his family settled shortly after he was born. A gifted student, Dr. Sullivan graduated from Atlanta's Booker T. Washington high school as Class Salutatorian, at Morehouse College magna cum laude, and earned his medical degree, cum laude, from Boston University School of Medicine in 1958. His postgraduate training was at the Cornell Medical Center followed by a clinical fellowship in pathology at Massachusetts General Hospital, and a research fellowship in hematology at the Thorndike Memorial Laboratory of Harvard Medical School, Boston City Hospital. In 1966, he became co-director of hematology at Boston University Medical Center and, a year later, founded the Boston University Hematology Service at Boston City Hospital. Dr. Sullivan remained at Boston University until 1975 advancing to professor of medicine.

In 1975, Dr. Sullivan returned to Atlanta as the founding dean of what became the Morehouse College School of Medicine. Dr. Sullivan was president of Morehouse School of Medicine for more than two decades leaving in 1989 to accept an appointment by President George H.W. Bush to serve as secretary of HHS. He is an active health policy leader, minority health advocate, author, physician, and educator. His achievements in his HHS post were exceptional and include the following:

1. Leading the effort to increase the National Institutes of Health (NIH) budget from $8.0 billion in 1989 to $13.1 billion in 1993.
2. Establishing at NIH, the Office of Research on Minority Health, which has become the National Institute on Minority Health and Health Disparities.
3. Inaugurating the Women's Health Research Program at NIH.
4. The introduction of a new, improved Food and Drug Administration food label.
5. The release of Healthy People 2000, a guide for improved health promotion/disease prevention activities.
6. Educating the public regarding the health dangers from tobacco use.

7. Leading the successful effort to prevent the introduction of "Uptown," a non-filtered, mentholated cigarette.
8. Inaugurating a $100 million minority male health and injury prevention initiative.
9. Implementing greater gender and ethnic diversity in senior positions of HHS.
   (a) The appointment of the first female director of NIH.
   (b) The first female (and first Hispanic) Surgeon General of the U.S. Public Health Service.
   (c) The first African-American Commissioner of the Social Security Administration.
   (d) The first African-American Administrator of the Health Care Financing Administration (now the Center for Medicare and Medicaid Services).

In 2003, Dr. Sullivan helped create the Sullivan Commission on Diversity in the Healthcare Workforce with a grant from the W.K. Kellogg Foundation to Duke University School of Medicine. The commission was composed of 16 health, business, higher education, and legal experts and other leaders. Their mission was to make policy recommendations to bring about systemic change to address the scarcity of minorities in the health professions. This was a time when enrollment of racial and ethnic minorities in nursing, medicine, and dentistry has stagnated despite America's growing diversity. The Commission's report provided the nation with a blueprint for achieving diversity in the health professions [11–14].

Dr. Sullivan is the recipient of more than 70 honorary degrees. He is the author of *The Morehouse Mystique: Becoming a Doctor at the Nation's Newest African American Medical School* (with Marybeth Gasman, 2012, Johns Hopkins University Press) and his autobiography *Breaking Ground: My Life in Medicine (with David Chanoff, 2014, University of Georgia Press)*.

Issues Discussed in This Chapter

- How to deliver unexpected or sad news
- How to "read" your patient

- What you can offer when there is nothing left to offer
- The SPIKES protocol and how to use it
- Unconscious (intrinsic) biases and patient care

Study Guide

1. If the information you have for the patient is grievous or life changing, how should you communicate that to the patient?
2. What are some examples of implicit biases?
3. What can you offer a patient whose condition is hopeless?

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Chapter 10
Special Considerations in Pediatrics: "[A] child is not a little adult…"

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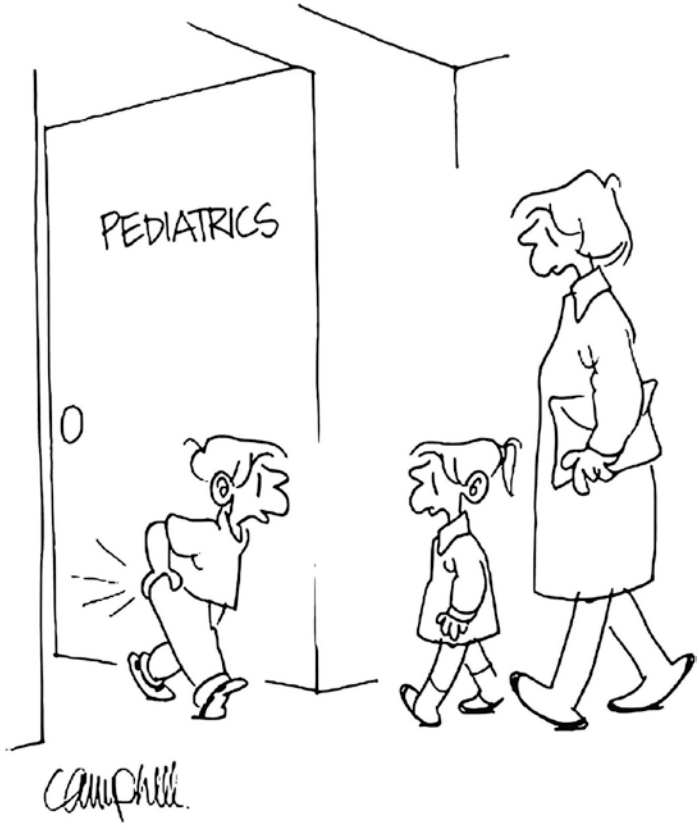

"Don't try to turn tail and run. That's just what they want."

A person's a person, no matter how small.

Dr. Seuss

Journal of proceedings and Addresses of the Annual Meeting. National Educational Association (US): 336, 1902.

Pediatrics is one of the primary care specialties. The pediatricians or family practitioners who include pediatric patients in their practice take on the responsibility of acting as a first contact for children and their families in the

event of illness. These physicians also provide follow-up care, regular physical exams, and ill child evaluations. The pediatrician has the satisfaction of following a child from birth through late adolescence, and is often the first adult outside of family members with whom the child establishes a social relationship. Participating in the physical and social development of the child is a very satisfying part of providing pediatric care.

Where the pediatricians' practices differ from those of adult medical specialists is in the special challenges and opportunities of caring for the newborn, infant, child, preadolescent, and adolescent. Most adults between the ages of 20 and 50 rarely visit their doctors' offices except for an acute illness, such as a fever or URI, a chronic symptom such as a cough or GI reflux, an injury, or the new onset of pain. The well-child visit, on the other hand, is an important part of maintaining a child's health, and includes immunizations, first year of life visits, physical exams to check for normal growth and development, and for school and sports participation.

You will learn in your clerkship how to examine a newborn baby, always a delight if you are not rushed, how to perform the elements of an age-related well-child visit, how to deal with common but potentially serious problems of the newborn and premature infant, and how to deal with common problems of the growing child and adolescent. A detailed discussion of the problems you will run into in a pediatric clerkship or residency is beyond the scope of this chapter. Rather, in this chapter we will try to give you some techniques on how to make the clerkship more fun, meaningful, and productive.

A special challenge for pediatricians is how to balance the medical needs of their patients against the desires and biases of those responsible for their care at home (for convenience we will call them the parents). In the first years of life, children are totally dependent on their parents for healthcare. During this period, the conversation in the medical office is between the doctor and the child's parents. As their patients grow and mature, pediatricians can spend time

speaking with the child. For the very young child, this will mostly be social conversation, or play.

In the case of the somewhat older child, you may question your patient directly to bring out signs and symptoms of disease. This will depend on the child's level of maturity and physical development. During the part of the consultation when you discuss how to approach treatment, if any is needed, very little of the conversation will include the very young child.

As your patients get older, they can contribute more information about symptoms and the course of any illness. If you are able to involve your patient in the beginning stages of the consultation, you will find they will cooperate more fully with the exam process. Although you might easily engage the older child during the socialization and exam process of the consultation, it is just as important to include the older child and adolescent in conversations concerning the diagnosis and any recommendations for treatment.

Wise pediatricians and parents recognize that an older child is competent to participate in at least some of that conversation, often showing insight into school and daily routines that influence treatment regimens. Older children might wish to raise concerns about healthcare routines that may not be compatible with their schedule or social life. While the parent may try to maintain control over the details of their child's treatment, with the older child, preadolescent, and adolescent, control of the treatment regimen falls increasingly into the child's hands. The doctor should therefore enlist their patient into any discussions about treatment options. Some children as young as 7 years can give information about their symptoms and also help in figuring out the best way to approach their treatment. Many adolescents can coordinate their own care, with little parental supervision.

Including the child in discussions and decision-making about any illness has an added benefit. This is an opportunity for your patient to have an adult interaction in a safe and controlled atmosphere. This will foster experience and

confidence in the ability to relate to an adult during a conversation about an important subject—in this case his or her health. Children can participate actively in their healthcare, and when included in the treatment plans, will engage and cooperate to a greater extent with the plan.

With the younger child, put your patient at ease by making the physical exam a sort of playtime. You will find this comes quite naturally. Describe everything before you do it. Gently advise your patient when something you are about to do will not feel good. Use words or expressions they will understand.

For example, when examining the very young child, say you are about to use the otoscope to see what new words they have learned today. Ask the child to blow out the flashlight you use to exam his throat. He will feel more in control. Do a simple magic trick, like taking a shiny coin out of their ear and giving it to them. Give them a picture book when they first get on the exam table. For the older child, if you or your assistant know a quick card trick or how to juggle, that will put them at their ease and make going to the doctor a playtime experience. Try to distract the child during any part of the exam that might cause discomfort, and especially when giving an injection. Giving neonates and infants 20% to 30% dextrose solution in a bottle has been shown to be effective in reducing pain [1]. See below for an excellent summary article on practices to reduce pain when giving a vaccination [2], and as a side note when placing an IV in children [3].

With the preteen, encourage your patient to enter into the conversation. In many cultures, children are encouraged to remain silent in the company of adults, and on these occasions, parents may answer for the child or interrupt a conversation between the doctor and the child. A good way to control the consult is to maintain a triangle of conversation, with the pediatrician at the apex and the parent and child slightly separated. That way you can turn to the person with whom you want to address a particular part of the conversation. If necessary, have the parent on one side of you, and

the child on the other. You may have to interrupt the parent with a slight wave of the hand or address the child by name. If this does not work, you just have to accept it and continue to try each time you see them in your office.

The parent may feel the doctor is not showing respect for the parent's authority, or that the child is not ready to take on responsibility for his or her health. Explain (but do not lecture) that by bringing their child into the conversation you will not only gain the child's confidence and trust, but a successful interaction is an opportunity to learn polite adult behavior, increase confidence, and demonstrate maturity. Most pediatricians will recruit the preteen and teen into the question and answer part of the exam, and the normally developing child will often eagerly participate. This is a good opportunity for the child to learn about turn-taking during a conversation. As with the adult patient, you should always show respect for both the parent and your patient by listening carefully, being attentive to their needs, and making certain all their questions are met.

Many parents may feel guilt or anxieties concerning the origins of their child's illness. They are reluctant to raise these fears but you, with some discretion, must address them in order to arrive at a practical course of treatment. Otherwise the parent might believe one possible source of the problem was not considered, and might be tempted to seek another doctor's diagnosis and opinion, thereby wasting time and money. Address all questions honestly. Parents need to know why their child is ill. This is one of the important goals of any medical consultation. If parents are distracted during the discussion of the treatment plan, ask them to repeat back to you any point they may find confusing. Repeat the plan. If you believe the child is old enough to understand, ask him or her to repeat the plan.

Before they leave your office, you, your patient, and parents should be in agreement as to what the problem is, what caused it, and how to deal with it. They should be able to "say back" to you the diagnosis, the treatment, and the plans for follow up. Be certain the treatment plan and your

impressions are written down. Some situations call for you to be discrete but always truthful.

Caring for the Teenager

We know of young adults in their 20s, lifelong patients of their pediatricians, who become quite upset when told they will be referred to an internist because of their age. On the other hand, some teens refuse to visit the same pediatrician as their younger siblings, finding a doctor's office that caters to infants and toddlers and decorated with cartoon characters too juvenile for their sensibilities.

The best doctor for teens is one who has a long-standing relationship with them. However, families move, doctors retire or relocate, or you may start a pediatric practice and decide not to treat teens. Adolescent medicine is a subspecialty of pediatrics dealing with the problems of teenagers.

To effectively communicate openly with a teen, you must practice the behaviors we discuss in Chap. 4. Teens will respond positively toward doctors who can talk openly with them in a safe and comfortable office environment and in an unhurried manner. Of particular importance to most teens is to find a pediatrician of the same sex. Some teens respond better to an older doctor, some to a younger doctor, some to a doctor in authoritarian dress and demeanor, and some to a doctor who eschews those trappings.

Teens are famous for their unpredictability, fickle behaviors, and nihilistic approach to any guideline or suggestion, and their opinions can change faster than their thumbs can beat out a message on their phones. Your most important job is to communicate well and focus your questions to the teen and not to the parent. At the end of the visit, you should ask your teen patient how it progressed. A shrug of the shoulders is an affirmative. If it did not go well there will be anything from no response to a stinging, in your face, review. Listen carefully. Acknowledge that you are now aware of their concerns. Do not be defensive.

Some teens may prefer to speak with the doctor without the parent in the room. The teen may state this desire spontaneously, or after a certain age (sometime after puberty) you can ask the parent and the teen, at the same time, if they would prefer to start the interview and exam with just you and your patient. Make certain you make it clear that you will call in the parent after the interview and exam. You can get a lot of information from the response of both. A same-sex chaperone during a physical exam with a teenager is always mandatory, even if the physician is of the same sex as the patient. This is an inconvenience, but just one misunderstanding can ruin a career.

A private exam is an opportunity for the child to discuss issues they believe will result in either increased tension or outright confrontation with their adult guardian or parent. Some parents balk at this, believing they have a right to be present and have been frozen out of an important conversation. Explain that the alternative to a parent not agreeing to their child's request for private time with the doctor is to not give their child the opportunity to discuss a bothersome health issue with an expert. After the private consultation, you can ask the teen if he or she would like to bring the adult into the conversation, if appropriate. You can ask the teen what they do not wish to discuss with the parent and why. As with guilt, it is the unanswered questions that engender the most anxiety.

Immunizations

After maintaining proper nutrition and hygiene, keeping a child's immunizations and medical records up to date is the single most important medical task a parent can accomplish to prevent serious illness. Yet some parents refuse to allow their children to receive the recommended vaccinations. It is beyond the scope of this chapter to discuss, in detail, immunization-hesitant parents, a group distinct from parents who are intransigent "anti-vaxxers." However, whether you

are a pediatrician, primary care practitioner, a subspecialist in surgery or internal medicine, or a researcher, because you are involved in healthcare you will probably get asked at some point in medical or social interactions your opinion of immunizations. Even in our own personal experience, we have close, older family members who refuse to receive influenza, pneumococcal, or pertussis booster vaccines. As a result, they are respectfully but forcefully asked to not visit any of our homes where there are infants or immunocompromised family members during the flu seasons. No amount of shaming, social isolation, or directly addressing their fixed, false beliefs will change their minds. Yet because we are respectful, we maintain a close family relationship, given the above constraints. The good news is the opinions of these older adults have not been passed on to their children.

As alluded to above, you will find hesitant parents who just want their fears addressed in a respectful and truthful manner. They are not "anti-vaxxers." They are aware of some of the false information being disseminated on the social networks and do not know what to believe. You are an expert source, and for those parents who are not suspicious of a "conspiracy," or that physicians have some sort of self-interest in recommending immunizations, or are not among those who are distrustful of any authority, you will find a receptive audience eager to obtain the best medical care for their children and willing to listen to what you have to say. We have referenced further resources on how to approach these families here [4, 5]. For a short history of the development of vaccines by year, see this article from the Children's Hospital of Philadelphia [6]. You will find a complete listing of recommended immunization schedules for infants, children, adults, as well as a catch-up immunization schedule here [7]. For a full discussion of the ethics specifically supporting the pediatrician's responsibility to inform parents of the overwhelming evidence supporting childhood vaccination, see this article by Chervenak, McCullough, and Brent in the *Journal of Pediatrics* [8]. The authors make a strong case that the child's primary

care physician, usually the pediatrician, has a strict legal obligation to report child neglect to local child health protective services in the event that parents, despite repeated attempts at counseling including the provision of accurate information, continue to deny childhood immunizations to their child. While strictly ruling out extreme measures, such as removal of the child from the home, the police powers of the state can be ethically applied to support immunization as a prerequisite for school attendance based on the concept of beneficence. This concept was discussed in an earlier chapter on professionalism.

An inexpensive way to obtain needed childhood immunizations is through a public health clinic. If you recommend a public health clinic to your patient, usually out of cost concerns, make certain you check your patient's immunization schedule at each follow-up visit. It has been our unfortunate experience to have asked a parent of a very ill child if his immunizations were up to date. The parents answered that they were, but as it turned out they were not and treatment for diphtheria was unfortunately delayed.

The Importance of Being Hopeful

(apologies to Oscar Wilde)

> *The miserable have no other medicine, but only hope.*
> —Claudio in *Measure for Measure*

In the previous chapter, we discussed the importance of hope in providing comfort to the patient nearing the end of life. We have included a discussion of the role of hope in this chapter on pediatric care because nowhere in life events does a devastating diagnosis create more shock and need for hope than when giving unexpected and potentially discouraging news to the family of a newborn or young child. Such a diagnosis can be shocking and can emotionally disable an adult. In today's world, as distinct from that of only three generations back, it is the nature of life to expect our children and grandchildren to outlive us as parents and

grandparents. Further, nowhere does a child's innocence and brilliant smile toward the future get more of a test than in a hospital ICU.

Carroll et al., in an article in *Pediatrics*, July 2018 [9], noted that not all unexpected news is bad news. They point out that our unconscious, predetermined attitudes toward a particular subject or patient will influence our behavior, including how we deliver unexpected news. These unconscious attitudes form our implicit biases. Usually used in the context of racial biases and how they affect the treatment of patients who look or act different than the treating physician, in the context of unexpected news, implicit biases include the physicians' attitudes toward patients with certain diagnoses. An obvious example is the following: On one occasion, shortly after we began caring for premature infants in a newly established NICU, the Chief Medical Officer of the hospital, an orthopedic surgeon, approached us. He opined that perhaps an NICU was not such a good idea, because "all the patients you treat will just end up with cerebral palsy," thus revealing several implicit biases. We addressed these biases, which he held perhaps because of patients he had treated or what he had observed many years previously. However, such misunderstandings and poor communication can result in real suffering.

Some biases are not so obvious. Many years ago, we cared for a 24-week premature baby born after a prolonged period of ruptured membranes marked by amnionitis. Meticulous nursing care and weeks in the NICU resulted in weaning the baby off oxygen, full nipple feedings, and readying the baby and family for discharge. As part of the routine protocol at the time, a CT scan prior to discharge revealed extensive damage to the brain white matter, periventricular leukomalacia. The nurses gave the news to the parents, who were at the bedside when the baby returned from the imaging suite. Although the family had been counseled concerning the outcome statistics of 24-week preemies, nevertheless the news was understandably upsetting. Naturally, the family was distraught.

We were paged stat to the bedside. We reassured the parents that their role had not changed one bit since before the baby went for the test. Their job, as is any parent's, was to raise the child to achieve the best possible outcome given the child's potential. While that potential might be diminished from what they had expected before complications affected the pregnancy, just as before the test, we did not have any idea of what that potential would be. Of course, the news was a disappointment, and as Carroll et al. point out, although the parents mourn for the loss of what they thought they had, they still loved what they did have.

How might this have been done in a manner to avoid a situation where the family is devastated and hope has been withdrawn? In the last chapter, we discussed how to foreshadow what you are about to say, a kind of verbal warning that what is to come is not going to be pleasant. But be careful how you frame what you are about to say. Your words will be remembered forever. Do not start with "I have some bad news…" or "I'm sorry but…" These statements reveal your implicit bias about the diagnosis. A child with spina bifida may not turn out to be bad news, but it can be unexpected if prenatal care was lacking. A child with cerebral palsy may not be a source of grief for what the child cannot do, but rather of great pleasure and accomplishment for what the child can do. A fetus with Trisomy 21 will result in different decisions for different families.

When we have to deliver news to a family that might not meet their expectations, it is important to consider our implicit bias, rehearse what we are about to say, make certain the news is given by the doctor and any other professional who has become close to the family, and in a quiet space. Frame the news, if appropriate, as unexpected. Listen to the parents' response. Do not be somber. Every baby is an opportunity for joy, except in rare cases. Offer hope, a plan, resources, and guidance. Make clear you and the medical system will not abandon the baby and the family.

Of course, some news is clearly bad. In these cases, you can offer comfort, guidance toward resources, and expertise as the problem progresses. Never try to predict the future. There is a great temptation to display your newly acquired knowledge, but you do not know to any degree of certainty what will happen in the next hours, days, weeks, years. And again, never let your families feel you are abandoning them.

Professionalism in Pediatrics

In an earlier chapter, we discussed the concept of professionalism. The principles we touched on span the spectrum of all medical specialties and subspecialties, including basic science and clinical research. However, in pediatrics there are certain issues requiring special expertise and they merit mention. A further in-depth discussion on how to teach and evaluate professionalism in general and in pediatrics in particular can be found here [10]. Previously we emphasized that professionalism is never a completed process. It is a continuing journey of improvement and education. As we spelled out, professionalism is a manner of becoming, and one is in the process of becoming throughout one's professional career.

The American Board of Pediatrics lists the following as principles of professionalism that can be measured and that the Pediatric trainee is expected to be able to practice as part of the core curriculum. The medical student is not expected to fully master these principles; however, it is important to know what they are—excellence, humanism, accountability, and altruism. The incorporation of these four principles can be demonstrated by the trainees' behavior and also measured by examining trainees' clinical competence, communication skills, and ethical understanding.

Since the recognition of pediatrics as a specialty within medicine, pediatricians have been advocates for the individual child and for all children. The recognition that children are not just "little adults" has been one of the founding

principles of both the American Pediatric Society and the American Academy of Pediatrics [11].

The pediatrician must care for the child in collaboration with the family. The special nature of this responsibility lies in those cases where the concept of beneficence applies to the child and may diverge from what one or the other of the parents believes is best for the child. A good example is when the parents are confirmed in their false belief that the risks of immunizations exceed the benefits that would accrue. Another example might be concerned with a family in transition, divorce, or economic inequities between the mother and father and where or if the child should receive medical care.

While compassion and empathy are essential values for any physician, a pediatrician must try to understand pain, fear, and the ability to trust from the child's point of view as well as from the point of view of his parents. The pediatrician must evaluate the child's ability to understand and communicate, and involve children in their care given the constraints of understanding and communication. This is also critical when it comes to informed consent and dialogue as to treatment.

We also wish to emphasize the values without which one cannot be a truly outstanding physician in any field. Patient well-being is the primary motivation of truly caring for your patient. "The patient comes first" is not just a shibboleth the authors learned in medical school 55 years ago; it is as true now as it was then. "Altruism and advocacy" are considered core values of professionalism by the American Board of Pediatrics. A prime example of the importance of both values is in the story of the Flint River water tragedy and Dr. Mona Hanna-Attisha's courage to save her community's children [12].

In our experience, those doctors who practice general pediatrics are committed to the idea that their patients' health is their first priority. Pediatricians are among the most accessible and dedicated of our colleagues. In the movies, the pediatrician is often portrayed as a kindly dedicated

physician. Our observation in working with our colleagues bears out that perception.

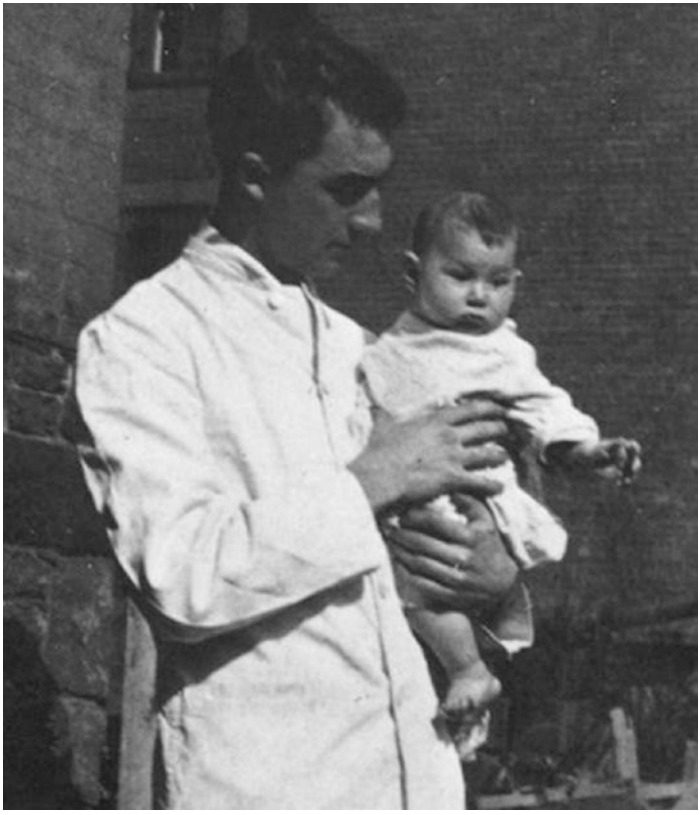

Photo Courtesy The Jean V. Naggar Literary Agency, Inc.

William Carlos Williams
Physician Poet

William Carlos Williams was born on September 17, 1883, in Rutherford, New Jersey. He knew from an early age that he wanted to write and be a doctor. Williams studied medi-

cine at the University of Pennsylvania, where he met Ezra Pound, the poet, who mentored his writing and assisted with the publications of a collection of his poems, *The Tempers*, published in 1913. In 1910, Williams begun his pediatric practice in his hometown. He continued to publish, writing plays, poems, novels, and essays. He was a major writer in the modernist movement, helping to create a clear American voice. A heart attack in 1948, which was followed by a series of strokes, resulted in his retirement from medical practice, but he continued to write until his death on March 4, 1963. His awards include the National Book Award in 1950 and the Pulitzer Prize in 1963.

The Dead Baby
by *William Carlos Williams*
Sweep the house
under the feet of the curious
holiday seekers —
sweep under the table and the bed
the baby is dead —
The mother's eyes where she sits
by the window, unconsoled —
have purple bags under them
the father —
tall, wellspoken, pitiful
is the abler of these two —
Sweep the house clean
here is one who has gone up
(though problematically)
to heaven, blindly
by force of the facts —
a clean sweep
is one way of expressing it —
Hurry up! any minute
they will be bringing it
from the hospital —
a white model of our lives
a curiosity —
surrounded by fresh flowers

Issues Discussed in this Chapter

- Why pediatrics is different than other medical specialties.
- The role of the pediatrician.
- Older children can be encouraged to contribute to discussions about their illness and their management.
- A pediatrician must communicate effectively with both child and parent(s).
- The medical encounter can be an opportunity for a child to learn how to participate in adult style interactions.
- Some teenagers will prefer alone time with the doctor during the exam.
- Uses and pitfalls of digital communication.
- Talking about immunizations.
- Unexpected news and what not to say.

Study Guide

1. Describe how you determine when it is appropriate to interview a child, discuss an illness, and confer about treatment.
2. How do you calm a child to whom you have to give a shot?
3. How do you address the parent's concern that you respect their authority over their child while respecting the child's autonomy?
4. What is the essential information that parents must leave the office with?
5. What are some of the best behaviors to practice when communicating with a teenager?
6. What recommendations do you give parents who refuse to immunize their children?
7. Discuss conveying sad news to the parents of a newborn and how you would have managed the baby with periventricular leukomalacia.
8. What is meant by accountability when considering professionalism in pediatrics?

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Pediatrics, established in 1930, gave all pediatricians an organization to support their work to be a "beneficent influence on the life and health of those patients whom the pediatricians will reach" said Isaac A. Abt, in the first presidential address of the American Academy of Pediatrics on June 12, 1931.

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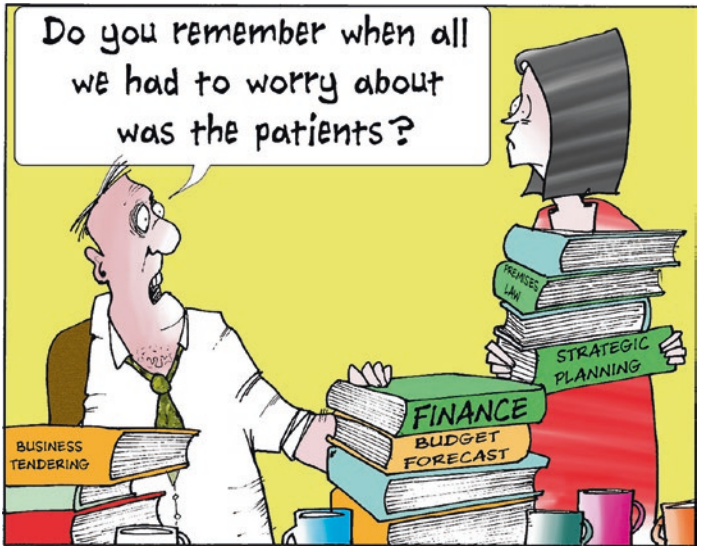
Chapter 11
Burnout: A Burgeoning Twenty-First-Century Problem

Barry Silverman and Saul Adler



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[T]his is the lesson: never give in, never give in, never, never, never, never-in nothing, great or small, large or petty – never give in except to convictions of honour and good sense.

Winston Churchill
October 29, 1941, Harrow School

Challenges to a Successful Career

A medical career is demanding. Multiple responsibilities make time management difficult. First and foremost is patient care: then there is record keeping (an essential part of the profession), committee meetings (occasionally useful), keeping up with the literature (a lifelong process), special projects (more about that in the next chapter), time devoted exclusively to family, and social engagement with the medical and local community. You must do all this while maintaining your own health habits of adequate sleep, exercise, and healthy eating. These multiple demands on your time, resources, and intellect can seem overwhelming. Furthermore, your position is not made any easier by the choices you have to make in each sphere: do I attend my child's play first or talk to my patient's family first; do I buckle to the pressure of the insurance company or do I do what I think is the best for my patient? Can I take the time to make a real meal or should I just do takeout?

What Is Burnout?

Burnout for the healthcare worker is the result of emotional exhaustion, depersonalization, or a feeling of reduced personal accomplishment [1]. The attributes and characteristics of your personality—empathy, a strong work ethic, a strong desire to learn, commitment, and courage—are the exact traits that can lead to emotional and physical exhaustion.

Burnout symptoms may appear any time in your career and is not infrequent in medical students, residents and fel-

lows, physicians and nurses [2, 3] who are very early in their careers as well as physicians well into their practices or research careers. David Rothenberger, the Chief of Surgery at the University of Minnesota, after reading the heart-wrenching suicide letter of a medical student, wrote: "I suddenly realize I have lived in denial of the dark side of the medical profession and its unwritten code—the code that says medical students should keep their mouths shut; that residents can be blamed since that is how they will learn; that repeatedly being pushed to the brink of exhaustion is a necessary part of being a caring physician; and that if a few drop out along the way, it is because they were weak and somehow deficient. Somehow I escaped, survived, and thrived, but it is not clear to me how that happened. Why was I not one of those statistics?" [4].

In *The House of God* [5], Stephen Bergman, writing under the pseudonym Samuel Shem, describes his brutal and often dehumanizing life as an intern, at the eponymic hospital in Boston: an experience filled with impossibly long hours, unsupportive attendings, and incurable patients. One fellow intern experiences a psychiatric breakdown and another kills himself. Bergman shows the reader, with pathos and humor, how the long hours, the lack of support, and the intense and stressful environment led to isolation and depression. As one intern notes, "How can we care for our patients, man, if nobody cares for us?" Bergman's answer to coping is you have to have connections, isolation is fatal and relationships are healing.

Current data indicate the prevalence of burnout is increasing among healthcare workers and especially physicians. The evidence suggests young physicians in training and particularly women are susceptible [6, 7]. A survey of US healthcare residents found evidence of burnout in 42%. Woman, who now constitute 50% of resident training positions, are reported to have increased odds of burnout ranging from 20% to 60% [3].

In 2015, Shanafelt et al. published the results of their survey indicating an increase in physicians' dissatisfaction with

work-life balance and self-reported symptoms of burnout relative to the general US working population. Shanafelt also reported [8] an increase in the prevalence of physician burnout from 2011 to 2014 with over 50% of all physicians experiencing burnout compared to the general working population prevalence of 28% [9]. A review in *The Lancet*, in 2016, noted "Physician burnout…has reached epidemic levels, with a prevalence near or exceeding 50% as documented in national studies of practicing physicians." [10].

There are consequences of this high rate. West and co-investigators cite lower quality of patient care, increased medical errors, longer medical and surgical recovery times, reduced patient satisfaction, lower physician productivity, increased physician turnover, and increased costs expressed in more tests and longer lengths of stay. In addition, they note physicians suffering from burnout experience more substance abuse, depression and suicidal ideation, and even automobile accidents [6]. Multiple programs focusing on personal wellness and institutional support systems, including the AMA "#steps forward" program [11], have been devised to assist physicians in practice to enhance their professional satisfaction, among other goals.

Physicians-in-training have always been tough, creative, resilient, and passionate. For the still idealistic student or trainee, being a doctor is not a job, it is a moral mission. Medical students and residents have always worked inhuman hours, in intolerable conditions, suffered demeaning remarks, public shaming, and impossible demands. Such insupportable behavior should never have been tolerated, and certainly should not be now. But it was, and often still is. The question we now ask is why do we see a dramatic increase in suicides and dropout?

Residents are smarter, better trained, more mature, and still as motivated as days past. Today's physicians are able to do more for their patients than ever before, and while there are certainly challenges not previously encountered, such as treating patients with bone marrow transplants [12],

metastatic cancer as a chronic disease [13], and cardiac assist devices [14], for example, physicians have never had the clinical and scientific support, as well as easy access to information, as they have today. It is not likely that "burnout" is increasing because of a sudden change in human pathologic mechanisms, disease vectors, or a significant shift in patient responsibility.

In 2018, in the online journal *STAT*, Talbot and Dean point out that the term burnout implicitly "suggests a failure of resourcefulness and resilience, traits that most physicians have finely honed during decades of intense training and demanding work." [15] Young physicians are justly proud of these traits and others necessary to function as a competent physician. Instead Talbot and Dean prefer the term "moral injury." As they explain, burnout is a symptom, not the disease. Rather, "The increasingly complex web of providers' highly conflicted allegiances—to patients, to self, and to employers—and its attendant moral injury, may be…causing the collapse of resilience."

What Is Moral Injury and How Does It Impact Providers and Patients?

The repeated lesson every medical student learns practically from Day One is their patient is their first priority; everything and everyone comes second. However, the lesson they learn in practice is the opposite. Practicing in the system, they learn the system prioritizes economic factors rather than healthcare exigencies. The cognitive dissonances arising from these competing goals are demoralizing. As Talbot and Dean write, "Continually being caught between the Hippocratic oath, a decade of training, and the realities of making a profit from people at their sickest and most vulnerable is an untenable and unreasonable demand… These routine and incessant betrayals of patient care and trust…[are] repeated on a daily basis…".

Back in the day we were not distracted by responsibility for making decisions about choices dictated by insurers, employers, or the necessity to perform administrative tasks for the billing office or the lab. Even our most reviled senior residents would go to bat for us if what we were demanding was in the interests of patient care. The major difference now is the healthcare system presents the physician and physician-in-training with multiple double and triple binds, where competing forces require decisions so at odds with each other that no matter which decision the doctors make, they will end up compromising their patients' care.

Words have meanings, explicit and implied. As Talbot and Dean point out, "burnout" implies victim blaming and places the onus on physicians; they are not strong enough, passionate enough, motivated enough; that is, not up to the challenge. "Moral injury" places the blame squarely where it belongs—a profit-driven healthcare system where decisions are prioritized toward profitability rather than patient healthcare. Physicians are constrained in their patients' care by choices determined by CEOs, administrators, accountants, lawyers, and protocols enforced by non-medically trained clerks, all hundreds of miles removed from the actual site of medical care and none with any responsibility for the patient's health or community well-being. Physicians are forced to make decisions they know will not be in their patients' best interests, and then have to witness the results of decisions they made but were not under their control. This "is the recipe for moral injury." [16]

Focusing on wellness, meditation, healthy eating, and free bottles of water do not get to the core of the problem. It is analogous to treating bacterial pneumonia with Tylenol and not antibiotics. We know we have to do something, but few are willing to articulate the political and economic changes to medical care that have transformed the practice of medicine over the past three decades. These changes have effectively converted physicians into labor commodities bought and sold by insurance companies, then marketed to large corporations and the public. From a profession once valued by its practi-

tioners as a place where their decisions could make the difference between life and death, physicians no longer have the autonomy that attracted them to medicine in the first place. No matter how hard they work, no matter how smart they are, they are just another cog in the wheel turning out cookie stamp healthcare determined by protocols for the generic patient not always validated by the best possible science. This removes any autonomy, and is an important contributor to a physician suicide rate now twice that of members in the military [17]. Physicians feel devalued.

How Does Moral Injury Affect Healthcare?

Williams et al. note that medicine's culture has changed the entire medical care team, and the quality of care provided for the patient has been transformed [18]. The more the physician is affected by conflicting goals, the more work performance deteriorates and unprofessional behaviors surface. Care is susceptible to error, and left unchecked quality of care and patient satisfaction and trust are undermined [19]. This behavior affects referral patterns, increases staff and physician turnover, and leads to a dysfunctional and unsafe work environment. Every hospital and large group practice have a committee of physicians to evaluate colleagues believed to be disruptive and abusive, and often the result is suspension or dismissal, causing more isolation and potentially a ruined career. Rather than punish the sufferer, perhaps what the committee should be examining is the underlying systemic causes leading to the aberrant behavior.

Who Is Affected?

Burnout is not associated with a specific type of practice or to the stage of a nurse or a physician's career. Burnout is reported in government, academic, and private practice settings and occurs in medical and nursing students, residents,

and after years of practice [20]. Rothenberger observed, "historically the origins of burnout were assumed to be rooted in the personal characteristics of a few susceptible individuals." He quotes Balch and Shanafelt who wrote, "one of the tragic paradoxes of burnout is that those who are most susceptible seem to be the most dedicated, conscientious, responsible, and motivated. Individuals with these traits are often idealistic and have perfectionist qualities." [21]. While personality characteristics are an important contributing factor in 50% of physicians experiencing burnout, there are clearly other factors: a loss of independence, corporate takeover of independent practices, and extra time required to work with the electronic medical record (EMR).

There is no question but that the EMR and cell phones can interfere with doctor-patient interaction. Text messages and emails can be intrusive, controlling, and time consuming. The complexity of the EMR often requires starting very early and staying late to accomplish the increase in administrative responsibilities, extending impossibly long duty hours.

In the increasingly corporate environment of healthcare for profit, the number of physicians assigned to a medical office is no longer under local control. This can result in longer office hours, less time with patients, and an on-call schedule determined by an administrator who has probably never seen the examining rooms of his physicians' offices. Equally troubling are decisions made about adequate compensation based only on productivity [22–24].

Why Moral Injury Is a Twenty-First-Century Problem?

Dan Ariely, an award-winning behavioral economist, and William Lanier, editor-in-chief of the Mayo Clinic Proceedings, discuss three main factors in modern medicine they believe are important drivers to physician dissatisfaction and burn out [25].

The first is "asymmetrical rewards," little praise or recognition for a job well done relative to the heaps of criticism and scorn following a mistake, especially if the result is a bad patient outcome.

Second, loss of "physician autonomy" as we have described above. Physician micromanagement, time constraints to evaluate patients, algorithms, documentation, and more documentation all reviewed often by clerks checking off items against requirements for diagnostic or procedural codes.

Third is "cognitive scarcity." As we discuss above, resources limited by third parties require treating physicians to make tradeoffs and then observe often preventable negative consequences. To quote from their paper:

> We propose that one main reason for this type of health management system is that we view the practice of medicine as a production function, a sort of "fixing-people production line," when, in fact, medicine should be viewed as a research and development activity. In a research and development practice, it is assumed that providers need time to think and reflect and that they need the flexibility to control their time, take different paths, and adjust as they make changes. The same is true for medicine, and unless we are going to recognize that such production line logic is the wrong metaphor for medicine, medical practitioners will experience more stress, fewer people will choose a healing profession, and patients will experience even worse outcomes. It is time to change direction and change the structure of the medical system from a system that focuses on micromanaging physicians' time and decisions to a system that focuses on long-term health. After all, if we trust physicians with our lives, shouldn't we also trust them to manage their own time and resources for our benefit?

The actual process of providing quality care has increased in difficulty. Treatment options are more sophisticated and expectations are higher. Patients who in the past could only be offered comfort measures are now expected to survive. Residents are expected to juggle their concerns about the welfare of their patients and administrative tasks related to insurance eligibility. Residents and physicians in practice rather than social workers often have to arrange for social services or rehab services when their patients are

discharged on multiple medications and treatment routines. The excessive workloads, inefficient work processes, EMR and clerical burdens, work-home conflicts, and lack of input or control by physicians are often met by a lack of organizational support structures and a sometimes tone deaf leadership cuture [6].

There is certainly a great deal of discussion concerning the time required to work with the EMR. There is no question, but that it can interfere with doctor-patient interaction. Text messages and emails can be intrusive, controlling, and time consuming. Completing patient history and physical exam notes, placing orders, writing follow-up notes by punching keys on a computer, and fitting complex ideas into neat little categories can waste time and heighten stress.

The EMR was originally developed to capture charges and increase institutional profitability: two functions it has improved. Patient care, on the other hand, has been impacted negatively by the EMR. The physician's workload increased, the EMR fails to capture and display in a meaningful manner all the patient's data including their symptom history and accurate description of physical findings.

Unquestionably the introduction of the EMR for healthcare record keeping has been very slow in advancing. The bottom line is that in the clinic and on the floor, it is still a developing technology. Just as the ECHO was to the stethoscope and the ultrasound to the flat plate or KUB, it will find its role. Do not let it discourage you, accept the challenge, embrace the progress, and if you have an idea or the background, volunteer to make it work better for you and your peers. If you find you are not as facile as some of the other students or residents, ask for help from IT. You can treat diabetic ketoacidosis, you know the mechanisms of shock and how to treat it, you can certainly learn to efficiently operate the EMR with proper teaching.

An interesting fact reported by Shanafelt and coworkers is that "physicians who spent less than 20% of their work effort on the activity they find most personally meaningful

are nearly three times more likely to be burned out than those who spend at least 20% of their work effort on such an activity." [6]

What Can Be Done?

A meta-analysis published in *The Lancet* [26] as well as a Cochrane study [27] reported on trials to reduce burnout. The conclusions of both studies differ somewhat, but only studies examining relaxation techniques were found to produce a low to moderate beneficial effect. We believe this supports the argument that the problem lies not solely within the individual, which the term "burnout" would imply, but is in fact a systemic problem resulting in "moral injury." We agree with Ariely and Lanier concerning the changes needed to the healthcare system, and more specifically of how policy makers' view of medical care as a "fixing-people production line" is one of the most pressing problems.

Moral injury is the result of three decades of profit-prioritized changes to healthcare to remake it into a free market service. One of the great debates of the 2020 presidential primary is whether Americans consider healthcare a human right. Healthcare, with its intricacies and gray areas between the consumer, the supplier, the buyer, the commodity and the emergency nature of many of the services simply cannot be expected to act like a classic free market responding to supply and demand. As the system for healthcare financing changes over time, we hope the reader will insist on control of all healthcare decisions that affect the local doctor-patient relationship.

As students and residents, you are probably not in control of how many patients you must see or reasonable work hours, or your work schedule. But if you find yourself stressed, ask for help. Check that. Demand help. There are ways around many resident and student duties that do not require years of postgraduate medical school and residency training.

If you feel you need help with your duties, find the training director or a senior physician who will listen. If no one will help, you may find a better fit in a different training program. Residents change training sites every year for a variety of reasons. There is no judgment associated with such a move. You may find after talking with the training director you will be asked why you feel you must move, and what she or he can do to convince you to stay! While a change in venue may seem drastic, remember that is but one of many solutions to whatever is causing your unhappiness and dissatisfaction.

If you are unsatisfied or feel that your program is not working for you, do not keep it to yourself. Odds are it is situational and therefore subject to mitigation. Talk to the training director or someone similar. Find a psychotherapist willing to help. Again, this is not a rare situation during the medical student and training years. There is no judgment associated with seeing a psychotherapist or engaging in therapy.

If you do have some control over your time, and you are not having self-destructive thoughts, consider the following. Do the same thing differently; sometimes you feel you are in a rut, the same routine and grind, and it is wearing you down. Look at your activities, see what you can change, and try a different routine. It can be energizing. This may include when you see patients, when you round, when you do your administrative activities, schedule procedures, and call back patients. Just a change in routine can be invigorating.

Take breaks! That may mean an extra coffee break, a brief nap after lunch, forcing yourself to get up from the computer every 60 minutes and walk for 5 minutes, or take a break from practice for a day, week, or month to refocus, rest, and enjoy your family.

Part of emotional exhaustion is an intense involvement with your colleagues and patients. Step back, look objectively at the most troubling issues, and try to be more

detached from them so you can intellectually analyze your discontent. Care for yourself; remember, helping other people is very demanding and the constant demands of their needs can wear you out and lead to exhaustion. Meeting your own needs and caring for yourself is an essential prerequisite to caring for your patients and staff. Techniques that promote physical and psychological well-being can be somewhat helpful to offset emotional exhaustion. This may include relaxing exercise, yoga, meditation, a walk in the woods, or relaxing hobbies. Consider going part time. A training program hates to lose a body, and if the choice is between part time or completely losing a trainee, most training directors would choose part time. It is not impossible to sit out a period of time. If your current program won't let you back in, there are many that will. Stay away from self-medication. It is an easy trap to fall into.

Heading into Practice

Leadership and organizational culture are important contributors to burnout and areas you must investigate before committing to residency, fellowship, or first post training employment. Is the organization transparent, that is, are they open and honest concerning their communication with employees? Is there an environment of collaboration, what is the opportunity for advancement, is there social welfare support such as time off for child and parent care, pregnancy leave, and professional development?

In West and coworker's review of physician burnout, they list causes of burnout and the solutions to consider at an organizational and personal level (Table 11.1) [6].

Medicine after training, to a greater or lesser degree, has allowed us to pursue unrelated interests on a regular basis,

Table 11.1 Burnout: causes and solutions

Problem	Organization solutions	Individual choices
Excessive workload	Fair productivity targets Limits to duty hours Appropriate distribution of job roles	Part-time status Informed practice and specialty choices
Work inefficiency	Optimized EMR Non-physician staff support Appropriate interpretation of regulatory requirements	Efficiency and skills training Prioritize tasks and delegate work appropriately
Home-work integration	Respect for home responsibilities in setting work requirements Include all required work tasks into scheduled work hours Support for a flexible work schedule	Reflection on life priorities and values Attention to self-care
Loss of autonomy	Physician engagement in establishing work requirements Physician leadership and shared decision-making	Stress management and resiliency training Positive coping strategies Mindfulness
Loss of meaning from work	Promote shared core values Protect physician time with patients Promote physician communities Offer professional development Leadership training and screening for physician burnout	Positive psychology Self-awareness of most fulfilling work roles Mindfulness Engagement in physician small group activities around shared work experiences

Table 11.1 used with permission of the publisher John Wiley and Sons, The Association for the publication of the Journal of Internal Medicine

attend children's school functions, help with homework, and enjoy many social activities with our wives and families. We workout, play sports, read, we study, we write, we take courses—some related and some not so related to medical care. It may at first seem impossible during your training years, when as a student and resident you have little control over your time, often determined by your professors and your attendings. However, an efficient use of your time and most importantly, learning how to say no when asked to take on a commitment that will result in over-extending yourself, will allow you, once you complete your formal training, to reflect and enjoy a balance to your life.

As we have related, moral injury (or if preferred, burnout) is common and it is expensive to your practice, to your emotional life, affects your patients, and your relationship to family, colleagues, and institutions like hospitals. The following are three examples we witnessed from our personal experience.

Sally M is a brilliant woman, superb physician, attentive and caring mother, a wonderful, loving and thoughtful spouse, an athlete, and a good cook. Sally wanted to excel at every level of her life, but there was not time in the day to complete all of the roles she had taken on without missing a child's school event, dinner with her spouse, and finishing all her office and hospital duties. Sally's colleagues were willing to cut her responsibilities but only with a major reduction in income and never becoming a full partner in the practice. These alternatives were not acceptable to her and after several miserable years, she realized she had to be on her own and have absolute control over her life and time. Her former practice partners stepped up to cover call with her and cover her practice whenever she asked. The result is patients who love and rave about her, contented children, and a very happy marriage.

Paul R was an exceptionally skilled surgeon who loved to be in the OR. He had personal problems at home, was frustrated with the demands of the EMR, especially computer orders and record keeping, he felt there were too many required hospital meetings, and way too many rules for the operating room, sepsis control, follow-up, and discharge

process. His release in life was having a good time, partying, and drinking. He was a lot of fun and his colleagues really enjoyed his company. Paul started to be careless and was involved in several malpractice suits. His colleagues did not notice his impairment but the nurses in the OR did and one afternoon demanded an alcohol blood level on the spot, which he failed. Paul had to be hospitalized in a rehabilitation facility for 6 months. Among other measures, he underwent extensive training in the efficient use of the EMR, received help and support from his nurse, and hired a physician's assistance to help with orders, recording keeping, and patient management.

Jerry K was a smart, skillful, organized physician whose partners recognized his special talents in running the business part of the practice, reading spreadsheets, negotiating with insurance companies, the hospital, and all the employees. He was the managing partner in a large practice. He enjoyed family, parenting, and building a new house. Over a period of time, partners and colleagues noted him to quarrel with staff resulting in increased staff turnover. In the hospital, he was reprimanded for belittling and talking down to the nurses. Then one day, after 18 years in practice and without any warning and notice, he turned in his resignation without informing his patients. Unable to please his patients, his colleagues, the hospital, his family, and all his employees, his frustration overcame him. Six months later, he was hired by a hospital to work half time in administration and half time just seeing office patients. He has never been happier.

In each of these case studies, there were clear warning signs that went unheeded. Be alert, be sensitive, and recognize what is happening so you can act before there is harm to patients, staff, colleagues, and family.

In this chapter, we focused on the current ills in the medical care system that can torpedo a devoted student or physician and the subsequent emotional and physical exhaustion that can result. Recognizing the signs and symptoms of

exhaustion in yourself and your colleagues will go a long way to preempting the syndrome before it seriously affects your life, your practice, and your patients.

Charles R. Drew M.D.

American Surgeon and Medical Researcher
"Father of the Blood Bank"

Permission to publish from Scurlock Studio Records, Archives Center, National Museum of American History, Behring Center, Smithsonian Institution.

Charles R. Drew was a truly remarkable man who combined academic brilliance, exceptional organizational skill, delightful charm, and extraordinary athletic ability to overcome racial barriers and prejudice and achieve one of the most significant medical advances of World War II: the development of the first large-scale blood bank, an achievement that saved countless lives. He then went on to Howard University and developed a surgical training program that educated a generation of African American surgeons. His comment to Mrs. J. F Bates a Fort Worth, Texas, schoolteacher reflects his drive and mission. "…So much of our energy is spent in overcoming the constricting environment in which we live that little energy is left for creating new ideas or things. Whenever, however, one breaks out of this rather high-walled prison of the "Negro Problem" by virtue of some worthwhile contribution, not only is he himself allowed more freedom, but part of the wall crumbles. And so, it should be the aim of every student in science to knock down at least one or two bricks of that wall by virtue of his own accomplishment." [6]

Dr. Drew was born to a middle-class family in June 1904. He had the opportunity to attend excellent schools though Washington was still segregated at that time. He excelled in track and football, and won the most popular student and best athlete awards. He attended Amherst College on an athletic scholarship and on graduation decided to go to medical school. Most African Americans at this time went to Howard or Meharry medical schools, but Drew was not accepted to Howard because he was short on English credits. He was accepted at Harvard, but they wanted to defer him for a year so he applied to McGill University which had a reputation for supporting minority students and allowed medical students to play on school teams. In high school and college, he was an average student but in medical school he excelled as a student as well as an athlete and graduated second in his class.

As a house officer at Montreal General Hospital, he became interested in shock and transfusions and began his research with Dr. John Beattie. He wanted to complete his surgical training in the USA, but it was very difficult to obtain a residency for an African American with the training programs convinced that white patients would refuse to be treated by blacks. As a result, he joined the faculty at Howard and progressed from surgical instructor to chief resident. On the recommendation of his chief and also based on his ability, he received a fellowship to train with Allen O. Whipple at New York's Presbyterian Hospital and earn a doctorate in medical science from Columbia University. Before Charles Drew, Presbyterian had never accepted an African American as a surgical resident nor extended staff privileges.

In New York, Drew worked in John Scudder's lab with a focus on shock and transfusion. They became interested in how to bank blood so it would be available when needed, and Drew chose this thesis for his doctoral research. Before World War l, it was recognized that sodium citrate would keep blood from clotting and dextrose could preserve it for up to 2 weeks, and successful transfusions with stored blood were carried out in England. The first "blood bank" was opened at Cook County hospital in 1937 by Bernard Fantus, who originated the term. Charles Drew began to review all the available studies including the Soviet investigations and in 1939 set up an experimental blood bank at Presbyterian. With the onset of World War ll, there was a crisis for blood in England and a national council was established to launch a nationwide blood banking program for the USA. Charles Drew worked with Scudder and E.H. L. Corwin to develop a large-scale program with Presbyterian as the model. They were successful and by August 1939 were sending plasma and blood to England. At this time, Drew decided to return to his faculty position at Howard; however, it rapidly became clear that the blood bank operation required expert supervision and organization and Drew was called back to New York as the full-time medical supervisor. While Drew did not discover plasma as a blood substitute, his organization and leadership

were largely responsible for the program's success. He introduced the bloodmobile and was considered the "father of the blood bank" a title he never claimed for himself insisting it was a team effort. Controversy arose before he left the blood bank program. Blood donations for England were segregated, and the Red Cross pilot project for the armed forces excluded black donors. Drew protested these prejudices and said, "One can say quite truthfully that on the battlefields nobody is very interested in where the plasma comes from when they are hurt…it is unfortunate that such a worthwhile and scientific bit of work should have been hampered by such stupidity."

Study Guide

1. How has EMR contributed to physician burnout?
2. The table lists problems that cause burnout including excessive workload, work inefficiency, home-work integration, loss of autonomy, and loss of meaning from work. List one example for each problem that is a suggestion to resolve the problem.
3. Discuss scenarios from personal experience leading to moral injury.
4. What do you think are some of the reasons physician burnout has increased in the twenty-first century?
5. List ways in which loss of autonomy affect work satisfaction.
6. What are asymmetrical rewards?
7. What can you do to prevent or treat burnout?
8. What is the Maslach Burnout Inventory?

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Chapter 12
The Joy of Medicine

Barry Silverman and Saul Adler

"Whew! Five surgeries in one day! Well, let's try to make this last one end on a happy note!"

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Not what we have, but what we enjoy constitutes our abundance.
– Epicurus

In the previous chapter on physician burnout, we warn you of problems you will encounter during your training and while you are practicing so you can be aware and respond appropriately. In this chapter, we remind you of the fun and joy to be found in the practice of medicine. Despite the sometimes intolerable work load, long hours of study, and personal and social responsibilities, we want to remind you how important it is to enjoy the pleasures and relish the intellectual stimulation and camaraderie you experience each day.

There is a joy, a pure pleasure that comes with the practice of medicine. There are many ways you experience this happiness: it may be the enjoyment of a personal relationship with your patient, the ecstasy of saving a life, the exhilaration of making a difficult diagnosis, the satisfaction of completing a difficult procedure or surgery, or just the wholesome fun of working with bright, committed, intelligent colleagues and team members to care for patients, complete a surgery, or solve a problem. Practicing medicine is a lot of fun, spiritually rewarding, and intellectually and emotionally satisfying.

Working in any intensive care unit is about as demanding, difficult, and emotionally draining as medicine can be. For example, in the NICU, parents have invested time and effort, physically and emotionally preparing for the baby's arrival, and they expect their babies to be healthy. When the baby is premature or ill, it can be a dreadful, nightmarish experience. The neonatal care team is empathetic to that anguish and concern; they feel it 24/7 until the crisis is over. Yet over shared experiences of teamwork, the entire healthcare team, often from diverse backgrounds, develop respect and are protective of each other and their families. In any successfully run medical or surgical specialty unit, patients and families often share in the unit comradeship. There are so many stories of families hugging and kissing their thanks and expressing their admiration for lives saved and prolonged.

One feels a special gratification when your name is called out by a seeming stranger in a mall or restaurant and says, "I

was critically ill in your unit, and I just wanted to say thank you." Or perhaps they are visiting you in your office for the first follow-up after a critical illness and they bring a thank you gift and want to take a selfie. These are some of the rewards that can only come from solving a life-and-death problem through your skill, knowledge, and training, and because you are part of a well-functioning team.

We have included in this book a number of biographies of famous and outstanding physicians. Appreciate how many have continued to contribute into their eighth and ninth decades. Examples include Shigeaki Hinohara who was seeing patient when he was over 100, Nanette Wenger who sees patients at 90, Helen Taussig, Eugene Braunwald, and Louis Sullivan who are and were active in their 80s.

A favorite example of a lifetime enthusiasm for the practice of medicine is Michael DeBakey, the renowned Baylor heart surgeon, who at age 88 was asked to consult on Russia's first president, Boris Yeltsin. Yeltsin had experienced a heart attack and was felt to need coronary artery surgery. His Russian physicians were convinced he could not survive the surgery, so Yeltsin consulted Dr. DeBakey who had a favorable opinion concerning coronary artery surgery. The successful result probably saved the Russian President. The story goes that after spending some time in Russia, Dr. DeBakey complained he had to return to Texas before his patients forgot him.

DeBakey had an appreciation for the profession: "In medicine, helping others while solving complex intellectual puzzles is our special reward." In the book *Medicine: Preserving the Passion in the 21st Century* [1], the editors Phil Manning and Lois DeBakey have compiled the personal reflections of 24 renowned physicians concerning their passion for medicine. Included in this collection was the late Phillip Tumulty, former Professor Emeritus at Johns Hopkins University who expressed the feelings of many doctors when he wrote:

> Because each day that medicine is practiced properly, I find a full measure of those fulfillments for which we all strive: intellectual enhancement, stimulation, and excitement; an opportunity to

> increase and expand the best qualities of mind and spirit; a chance to feel the thrill of bringing relief to fellow human beings through the best use of one's intellectual and personal endowments; and finally the daily experience of seeing and understanding more clearly the depths of human nature, with its intense complexities and eccentricities, its good and bad, its sublimity and depravity, its victories and defeats. A clinician is not merely a bystander looking at life as it flows by him; he is an active participant in it, at some of its most crucial stages involving his fellow human beings.

We noted in the burnout chapter that it is not uncommon for students, residents, and fellows to feel they are being criticized for lapses in medical care, for practicing physicians to feel the criticisms at tumor conference or case presentations, and how difficult that can be when the effort and commitment is so great. But there is another side to practice where you are treated with respect in informal meetings and social occasions by patients and other healthcare workers for your skills and devotion to service, and where you are constantly learning characteristics of the human condition that cannot be taught in the classroom.

Renewing the Passion

Sometimes you feel you are in a rut, no new challenges, the fun seems lost, the passion diminished. To find the joy and experience the fun, you may need to reinvent yourself. This can include developing a special expertise, altering your practice pattern, or volunteering to teach or engage in clinical research. In our own careers, we have at different times developed special knowledge on a variety of subjects ranging from expertise in ventilation physiology, pharmacologic treatments in late pregnancy, ICU workflow efficiency, causes and treatment of syncope, hypertension, and special expertise in dysautonomia. These projects, while infrequently resulting in published studies, meant we would often be asked by partners and colleagues to consult on difficult and complicated patients and issues associated with these problems. These requests are validation of the extra time spent on developing

these interests and provide gratification for a service unique to our medical community.

Working for our community professionally and the general community welfare is especially rewarding. We have worked actively in the local medical association and our professional societies. We volunteer at our public and not-for-profit hospitals and we teach at local seminars and to medical students in the clinics. These experiences provide stimulating, pleasurable, and gratifying change from our routine daily clinical practice.

Such activities and challenges, whether niche clinical care, clinical research, or administration, provide experiences unique to each individual role and present problem-solving opportunities in aspects of medicine other than those in the daily routine. They also provide engagement with colleagues outside of our immediate community, resulting in long-term friendships, and interactions with patients from a wide stratum of society. This last is critical to providing the physician the full panorama of life that cannot help but result in a well-rounded and more fully educated member of society at large.

Clinical Research Is Fulfilling

Clinical research can be especially rewarding. Dr. Mary Ellen Avery, recipient of the Presidential Medal for her work in developing lung surfactant, was famous for her aphorism, "All significant medical research begins at the bedside." Someday a patient will come to you with a baffling array of symptoms, or a surgical technique will not turn out as expected, or a patient will tell you he has started some daily routine and serendipitously a troublesome symptom disappeared. Be alert for these moments, and be on the lookout for clinical studies that investigate or treat the condition you want to investigate. It is an entirely different facet of medicine, and while many studies lead nowhere some may lead to an important discovery. We participated in almost every clinical trial of inotropic drugs for heart failure. All were dismal failures; then we were

part of a major beta-blocker trial for heart failure that was transforming, a true breakthrough that has saved countless lives. That was truly thrilling.

In 1977, we took the unexpected opportunity to study with the pediatric cardiologist, Dr. Norman Gootman, who taught us how to do cardiac ECHOs on the newborn when the technique was still in its infancy (pun intended). This led to a number of clinical studies. While we did not publish those studies, they did serve to educate us and our colleagues on many aspects of our patient's progress. On another occasion, we had a patient with recurrent ventricular tachycardia and episodes of near sudden cardiac death. The medical student reported this condition was being treated in Europe with a drug Amiodarone, a drug not available in this country. We found that the FDA would allow us to obtain a special use permit as an investigator if we did not charge patients. We were able to provide the medication that was life saving for this patient and helped many more patients before it was available by prescription.

There were many more occasions, some serendipitous, some we had to work for, and some, in retrospect, we let blow past us. But by staying alert and receptive to the opportunities, you will find exciting episodes in your careers. If nothing else, it will lead down a path to self-discovery and knowledge.

A Medical Degree Opens Many Nonclinical Career Choices

Many physicians feel like they are one trick ponies. They were trained to care for patients and with that training there is nothing else they can do. They are trapped. *Not true*. Your medical degree gives you opportunities no other degree can confer. Having finished medical school you are a proven performer in the sciences, you know how to be a team player, you have developed critical skills, you know certain management techniques, you are an excellent learner and most likely

a competent teacher, you know how to use logic to solve problems and advance ideas, and you do not shy away from making critical decisions.

You are a trained observer. You know how to work under pressure, meet deadlines, and think outside the box. You may not know it, but you have been collecting stories and writing narratives since you started your clinical years. You can actually make this into a new career. Take some creative writing courses, or if you prefer, you can serve as an editor or content provider for online or print medical journals or for lay consumption.

Insurance companies, healthcare companies, and hospitals are always in the market for well-educated administrators. Take a starter position in a healthcare company or a hospital and get your MBA or a masters in healthcare administration. It will be a far less grueling schedule than your current one, and the starting salary will probably be a lot higher. Those 5 or more years of residency and fellowship you thought you wanted to complete can turn into a 3-year advanced degree, and you can have a career you enjoy rather than suffer through one you resent. The knowledge, skills, and techniques you learned in medical school and whatever level of training or years of practice you completed are valued in every area of business, science, management, and administration.

Elements of a Successful Career

A successful, satisfying medical career, wherein you will find joy in using your intellect and skills to help the sick and the helpless, requires tenacity and effort coupled with resolve and purposefulness, continuous learning, and maintaining your skills. However, you cannot achieve happiness in medicine isolated and alone. It is essential to maintain friendships with some and collegiality with others, to support your colleagues and maintain rapport with your staff, nurses, and administrators.

Do not despair if you feel you are not up to the challenges; the admissions committee members know what they are doing. Or that it is your fault when something goes sideways with one of your patients; not every outcome is perfect. Burnout is most likely to occur in those students who start medical school as the most caring, dedicated, and determined to excel, but are then faced with sleep deprivation, social isolation, impossible schedules, as well as upsetting personal events that tilt an already delicate balance of coping.

Later, during the clinical years and into residency, trainees are frustrated when caring for seriously ill individuals whose problems transcend their diseases: individuals with illnesses related to poverty and societal structural issues causing harm no medicine can ameliorate. Some of these challenges you will be able to confront, and some you will not. Not all of the outcomes depend on your knowledge and dedication. In many cases, a less-than-satisfactory result is due to a number of factors, not least of which are the capabilities of the institution you serve.

You may find you do not enjoy caring for patients, or that the strenuous schedule you are experiencing now will continue if you take a career path in surgery or obstetrics. Be aware that the hours you work as a trainee are much greater and the stress of pleasing everyone from the patient to the attending to your family is much greater during the training years than they are when you are in practice. That said, there are strains and tensions, just of a different nature, and you may feel the passion you had for medicine is still there, but caring for patients is just not your thing.

Do a self-assessment. Decide what it is you like best about medicine. Focus on those factors, for therein lies the joy. Medicine offers many specialties that do not involve direct patient care. Maybe you do not like surgery, but would like forensic pathology. Consider a career in public health, environmental studies, medical engineering if you have the background, pharmacology patient trials, or journalism. But if you want to make a clean break, then you have proven you are smart, motivated, and willing to work hard. You will be able to parlay that into a new career you will enjoy.

Permission for photo and biography: International Department St. Luke's International Hospital and the family of Shigeaki Hinohara from Kaori Wakamatsu

Shigeaki Hinohara
A Humanist Known for His Caring Spirit

Dr. Hinohara continued seeing patients until months before his death at age 105 and frequently offered advice on how to live well. Described by his colleagues as Japan's

national treasure, he headed five foundations in addition to being the president of St Luke's International Hospital in Tokyo. He began working during World War Two, as a doctor at St Luke's in the 1940s. During the war, he helped to treat victims of the firebombing that destroyed large parts of the Japanese capital. A great music lover, Dr. Hinohara, at the age of 88, wrote a script for a Japanese musical entitled The Fall of Freddie the Leaf. The show was first performed in 2000 and Dr. Hinohara also acted in the production, dancing with children. Dr. Hinohara frequently appeared on Japanese television, urging audiences to have more fun in their lives and to ward off illness by always giving themselves something to look forward to. On TV and through a best-selling anthology of essays called *How to Live Well*, he encouraged others to do away with strict rules on when to eat and sleep. One of his last pieces of advice was: always take the stairs and keep up your strength by carrying your own bags. "We all remember how as children, when we were having fun, we often forgot to eat or sleep," he once said. "I believe we can keep that attitude as adults—it is best not to tire the body with too many rules such as lunchtime and bedtime." His contributions to healthcare in Japan include introducing Japan's system of comprehensive annual medical check-ups—called "human dry-dock"—which have been credited with greatly contributing to the country's longevity. He was also a strong advocate of maintaining an active social life into old age. Dr. Hinohara became director of St Luke's in the early 1990s and had oxygen tubes installed throughout the building in 1994 to prepare for mass casualties if an earthquake struck the capital. The next year, a sarin gas attack on Tokyo's metro by members of a cult killed at least 12 and injured thousands, but the hospital was able to cope with the number of patients because of Dr. Hinohara's preparations. A most energetic person, many tributes have been paid to Dr. Hinohara, including by *The Japan Times* journalist Judit Kawaguchi, who knew him well.

She told the BBC World Service World Update that he had amazing energy and drive. "I met him when he was already in his 90s and I would say he drastically changed my mind about

ageing because even then he was working 18 hours, 7 days a week, and he was the most energetic person I've ever met," she said. "He believed that life is all about contribution, so he had this incredible drive to help people, to wake up early in the morning and do something wonderful for other people. This is what was driving him and what kept him living." She added. "He always had today's goals, tomorrow's and the next 5 years. He was just an amazing, amazing person and everybody who met him was transformed because of him" [2, 3].

Study Guide

1. There is much joy in medicine. Where do you find that joy?
2. Name five aspects of medicine that bring you the most pleasure or fun or satisfaction.

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