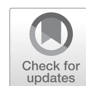
Chapter 8
A Challenging Experience: Inpatient Care



Barry Silverman and Saul Adler

B. Silverman (✉)
Emory University School of Medicine, Atlanta, GA, USA

S. Adler
Scottish Rite Children's Hospital (Ret.), Atlanta, GA, USA

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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."

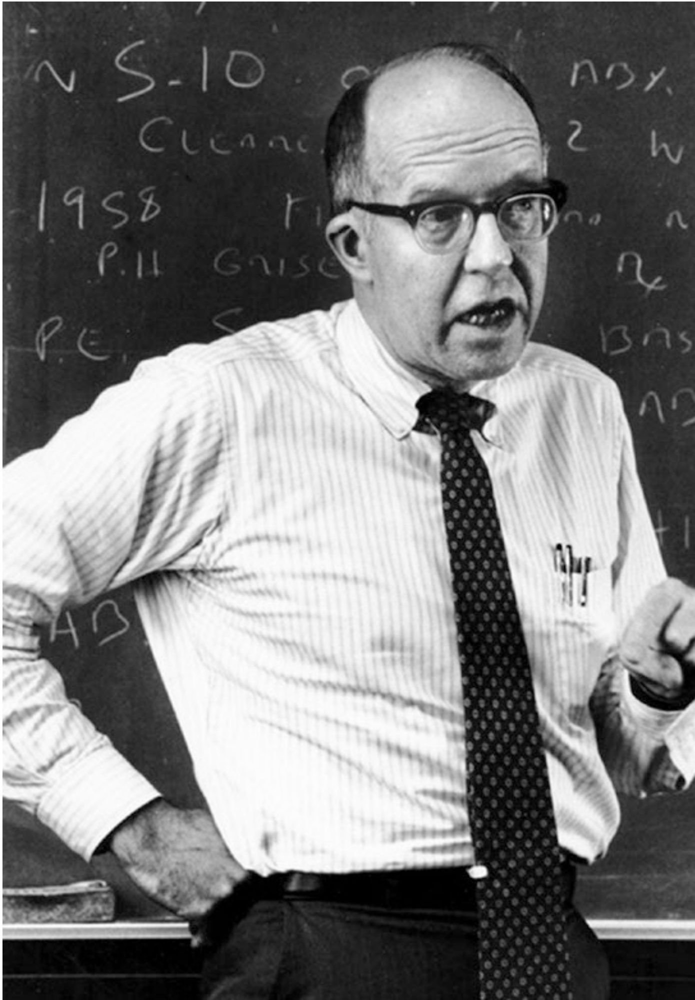
"Marianne Wallace did report me to the CEO, who filed a complaint with the Medical Executive Committee. They asked me to explain my actions. By that time I had figured out what had happened. I checked my cell phone records the next day and discovered I had called the main CRMC hospital admissions clerk 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 short-cuts….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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