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FROM THE EDITOR

Peking Duck Soup

Audiey Kao, MD, PhD

I know more than doctors," my mother confidently claimed. Despite practicing medicine for nearly 10 years, I still occasionally hear from my mom that my education and training as a physician do not compare to her years of experiential knowledge and expertise as a caregiver. In some ways, my mom cannot be serious—she is not licensed by the state to practice medicine, nor can she sort through a grocery list of differential diagnoses to determine the appropriate course of action. But in other ways, she and other mothers like her, armed with the healing powers of chicken soup, can teach their physician-children a thing or two about caring and common sense.

According to the World Health Organization's *Action Programme on Essential Drugs*,[1] a drug is considered essential if it is "as relevant today as it was 20 years ago," and satisfies 4 criteria. It must be (1) evidence-based, (2) efficient, (3) flexible, and (4) forward looking. To many, the chicken soup that our mothers made for us when we were sick can be classified as an essential drug.[2] But maybe more importantly, these criteria also characterize our mothers' abilities in their roles as caregivers that are as applicable and relevant for medical professionals today as they were more than 20 times 20 years ago.

> A special food was "the chicken of Rabbi Abba." Concerning its preparation, there is a divergence of opinion in the commentaries. It was assumed that it was prepared in such a way that after it was cooked, it was soaked in warm water for a long time until it completely dissolved. Rabbi Abba is said to have consumed this fowl as a remedy.[3]

> As far as possible, the meat should be that of hens or roosters and their broth should also be taken, because this sort of fowl has virtue in rectifying corrupted humours, whatever the corruption may be, and especially the black humours, so much so that the physicians have mentioned that chicken broth is beneficial in leprosy.[4]

> Chicken soup that is boiled neutralizes [body] constitution. This is [both] an excellent food, as well as a medication for the beginning of leprosy, and fattens the [body] substance of the emaciated and those convalescing from illness. Pigeon sucklings and all soups made therefrom have the special property of producing migraine headaches. . . . The partridge, if boiled, causes constipation. If it is boiled in its skin, it loosens the stool. The hen and the rooster have [even] more powerful stool-loosening action.[5]

While there has never been a randomized control trial on the therapeutic efficacy of chicken soup, mothers have long used observational, anecdotal, and intuitive evidence in their roles as caregivers and healers. In an era of increased

understanding about the biology and pathophysiology of disease, the emergence of scientifically driven, evidence-based medicine is critical to the advancement of medical care. But, as physicians, we should never loose sight that other information and evidence, oftentimes gleaned from careful observation, remains an important part of the therapeutic relationship.

Efficiency
Mothers are famous for their ability to juggle a seemingly infinite number of tasks in any given day. Time management, prioritization, and peer support are skills and resources that mothers draw on and that physicians increasingly need in the hectic environment of contemporary medical practice. Unfortunately, while these "efficiency" skills seem innate to mothers, they seem lacking in, and are not taught to, medical students, residents, and new physicians during their education and training. For example, physicians should to take advantage of the competencies of other professionals such as nurses, social workers, and chaplains in providing efficient care to their patients. While it is true that physicians need to manage their time better, it must also be noted that physicians do not have as much control over the conditions of their work environment as mothers, and thus true efforts towards efficiency, must address the "hassle factor" that distracts physicians from caring for patients.

Flexibility
There is no "basic" formula for the preparation of chicken soup. Some mothers add carrots, others may not; there seem to be an infinite number of variations. The fowl of preference in Chinese culture may be duck (of the Peking variety) rather than chicken—but, frankly, both birds will probably be equal in therapeutic value.

"Flexibility" also describes the different ways mothers relate to their children whom they love equally. Some mother-children relationships are easy while others are more difficult. One child will almost always obey, another will need closer observation and more coaxing. From the physician's perspective, the ability to interact differently with patients who have exactly the same illness is critical to establishing a therapeutic relationship. Thus physicians, no less than mothers, must be flexible and treat each person they care for as an individual.

Forward looking
Mothers are, by their nature, forward looking, devoted to and constantly protecting their children's futures. This longitudinal perspective that mothers have in the care of their children is a worthy of reminder for physicians. Physicians, too, look out for their patient's best interest, but sometimes our view gets myopic. Frequently physicians get swept up by the intensity of managing and treating an acute illness, and can lose sight of patients' long term well-being. There are few relationships outside those of the blood variety that are as important and intimate as the patient-physician relationship. Therefore, in many ways, our mothers remind us as physicians to balance our desire to cure at all costs and the need to care for our patients.

In the month of May when mothers are honored and motherhood celebrated, I want to say, "Mom, thanks for all of your support through the years. Love, your son.

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CASE AND COMMENTARY
When Is There a Duty To Inform? Commentary 1
Commentary by Samuel C. Seiden

Case
For the first presentation of his radiology elective, Scott was to select a film and discuss what he saw with the other students, residents, and faculty. He selected a chest film of a 57-year-old man, Mr. Walters, who had come to the Emergency Department several days before with a cough.

Scott decided the film was consistent with a diagnosis of chronic obstructive pulmonary disease. The next time he saw the attending radiologist, Dr. Carlson, Scott asked him to look at the film with him to see whether he concurred. Dr. Carlson began working through the systematic reading of the film with Scott—soft tissue, then bones. Then he pointed to some spots on a lower left rib and asked Scott, "What are those?" "They look like mets," Scott answered, and Dr. Carlson agreed they could be.

Scott pulled Mr. Walters' chart to verify his diagnosis and see whether the bony lesions were noted in the report. The radiologist's report said only: No acute pulmonary disease. Scott read the full chart entry. Mr. Walters had been in town visiting his daughter when he developed the cough. Because of his chronic lung condition, she had prevailed upon him to go the emergency room. The physician ordered the chest X-ray to rule out pneumonia. The discharge note said that, given his underlying lung disease, Mr. Walters saw his pulmonologist every 6 months. The chart said nothing about a chest X-ray that revealed possible bony metastases.

Scott asked Dr. Carlson whether they should call the radiologist who had read the film. "Hell, no. This guy probably knows all about his cancer. He came in to find out whether he had pneumonia and we told him he didn't. The discharge note says he'll be seeing his pulmonologist soon. I'm sure he's getting proper care."

Scott wasn't satisfied. Knowing that the examining radiologist notes all pertinent positive findings, Scott thought it possible that no one yet knew that Mr. Walters possibly had metastatic processes in his rib. Mr. Walters had gone home, and Dr. Carlson had said he couldn't be calling around the country to the docs of everyone who came into the ER to see what they knew and didn't know about that patient's overall health. That made sense. And certainly Scott couldn't take it upon himself to find out who Mr. Walter's physician was and call him. The guy would think he was nuts.

Scott mentioned the case to his wife that night, mostly to let her know about his diagnostic "catch." But Becky's response was all about Mr. Walters, and she didn't see things the way Dr. Carlson did.

"It's okay for you to practice on those patients," Becky said, "to peer and poke at them and talk about them. All for the good of medical education and the benefit of society. Now here comes a case where somebody might benefit right here and now from the fact that a student and a second radiologist took a look at his X-ray. That could only happen in a teaching hospital. You have to do something, Scott."

Scott didn't care for any of his options. Dr. Carlson had been clear that no follow up was necessary. He and Scott had no patient-physician relationship with Mr. Walters, this was not an emergency, and so on. If Scott went back to Dr. Carlson and received the same reply, that would have to be the end of it. Dr. Carlson was there to assess all of Scott's performance including his ability to follow instructions. Yet Scott was uncomfortable taking no action in Mr. Walter's behalf.

Commentary 1

This is a case that involves the ethical question of duty to warn. The core conflict, however, is less about duty to warn than about how one should handle disagreements with superiors, in this case a disagreement between a medical student on a radiology clerkship and his attending. The relevant medical history is of a 57-year-old man with a history of a chronic lung condition who presents to the emergency department (ED) with a cough. The ED attendings want to rule out pneumonia, so they order a chest X-ray that comes back negative. The student, Scott, has not met the patient, Mr. Walters, but chose his X-ray as one to interpret and present to his attending.

In doing the presentation, Scott and the attending observe what appear to be bony metastases, a diagnosis that was not made by the original radiologist or mentioned in the ED chart, either as having been reported from the patient during medical history taking or told to the patient as a present finding. Scott wants to follow up with Mr. Walters, but the attending believes there is no duty to warn because the patient probably already knows of the cancer, and, if he doesn't, someone else will probably tell him. The attending also notes that neither he nor Scott has a patient-physician relationship with the patient, implying either that there is no obligation to warn or that it may be inappropriate to warn. Scott is justifiably frustrated by this answer.

Why Warn at All?

The first issue of concern here is the possibility of a preventable medical error occurring, namely that a patient could have a diagnosed disease and not be aware of it. In the multi-factorial process by which errors occur, it is not hard to see where this one may have started. In the ED, the chest X-ray was ordered to rule out pneumonia, not to screen for bone cancer, and it seems possible that both the radiologist and the ED could miss the bone cancer because of their focus on the

question of pneumonia; a classic example of tunnel vision. Because documentation is stressed so heavily for legal reasons, it is hard to believe that a possible cancer diagnosis was discussed and not documented.

The central ethical question in this case pertains to the duty to warn. The attending presumably agrees that the patient has a right to know about his cancer diagnosis, but also believes that because (a) the patient probably already knows of the diagnosis, and (b) there is no established relationship with the patient, that there is no *duty* to warn. I disagree with this reasoning because I see little harm in telling the patient that he may have cancer, whereas I can see great potential harm in not telling him. I believe there *is* a duty to warn irrespective of whose patient Mr. Walters is. If the patient already knows he has cancer, I doubt he will be upset at having someone go to the trouble of contacting him to make sure he knows. In fact, I think it more likely that he will be appreciative, knowing that someone was paying such attention to his health, an action based on the ethical principle of beneficence. However, if he does not know of his cancer, withholding that information could delay potentially beneficial treatment until someone else makes the diagnosis. This is essentially contradictory to the ethical principal of non-maleficence (do no harm) because withholding the diagnosis could do harm if it delays treatment.

The only potential harm that I can see for the patient is if the diagnosis is false. If there is a high rate of false positives in X-ray diagnosis of bone cancer, it may be prudent for Scott to try to contact Mr. Walters' pulmonologist or another physician to try to confirm the diagnosis instead of speaking directly to the patient. If the concern is of a breach of confidentiality in the student viewing the X-ray, I would think that the informed consent provided when entering an academic medical center would be sufficient to justify the student's participation in this way.

In regard to whether a duty to warn actually exists in this case, I think it does. According to Opinion 8.12, "Patient Information" of the AMA's *Code of Medical Ethics*, "Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions." Moreover, as to whether it matters that the parties involved were on the patient's treatment team, Opinion 8.12 continues, physicians' "ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information."

How Do You Warn?

Accepting that there is an ethical duty to warn, the second question in this case, and the one that is the basis for my recommendation, is how might the student proceed in contacting the patient, given that the attending has instructed him not to do so. Learning how to handle these situations is particularly important because subordinates may frequently be hesitant to question their superiors' judgment. Furthermore, as I stated above, I believe not telling the patient is a potential medical error. It is my belief that we will only stem the epidemic of such medical errors if we maximize a cooperative team approach to medicine.

As I see it, the student has the following options, starting with the least desirable. First, the student could accept his attending's instructions, with the risk that the patient delays potentially beneficial therapy. Second, the student could attempt to contact the patient's physician without the attending's knowledge. This could jeopardize the student's performance review if the attending discovered that his instructions had been overruled. Third, the student could discuss this matter with another, perhaps more senior, attending, or even request an ethics consult. Some students may fear that if they take action contrary to the attending's instructions, the attending will be angered and might punish the student with a bad evaluation. A member of the ethics team at my medical school said that an attending who would take such punitive action has no business at an academic medical center. While this may be the case, I sympathize with this student's concerns, and suggest a fourth course of action that is really the basis for what we all must do to work effectively on the same team—learn to communicate in a professional manner, respect that we may disagree, and strive to keep the patient's best interests our primary objective.

My recommendation, therefore, is that the student politely tell the attending that he is unconvinced that the patient has been notified of his potential cancer diagnosis, and is not comfortable with assuming that someone else will make or has made the diagnosis. I would also tell the attending that, as a medical student, I have the luxury of the time to follow up with the patient or the patient's physician. I would explain that patients in academic medical centers accept the inconveniences of being "taught upon" by medical students, residents, and other health professionals in training, in part because of the better care and comprehensiveness that such teams provide. This a key example. If possible, I would communicate this to the attending by e-mail, because it removes the confrontational nature and gives the attending time to think about a response instead of just reacting to perceived second guessing by the student. In certain time-sensitive circumstances, the student might have to make this confrontation in person. If this information is not well received by the attending, the student might have to return to the possibility of calling an ethics consultation. The worst case scenario is that the student receives a less than favorable evaluation, but I would rather defend a poor evaluation then an avoidable poor patient outcome.

For a medical student and young physician, it is a vital skill to learn how to communicate and make suggestions to one's attendings without being threatening or questioning their seniority and experience. Of course, the student must know when to this, (eg, for a patient's benefit, not merely to point out the attending's having mistaken the embryological origin of the ligamentum arteriosum) otherwise he or she will quickly become the least appreciated student on the team. However, the notion that attendings are infallible and always right, is not consistent with the teamwork environment that we must foster in modern medicine if we want to reduce the thousands of patient deaths due to medical errors each year. This is truly a lifelong skill physicians must learn, for once we, the medical students and young

physicians become the senior attendings, we will need to be able to accept this feedback from our own students.

Samuel C. Seiden is a medical student at the University of Chicago Pritzker School of Medicine.

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CASE AND COMMENTARY

When Is There a Duty To Inform? Commentary 2

Russell Burck, PhD

Case

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Commentary 2

Ethics asks, "What is the good or not so good? And how do we know"?1 Not everything that ethics authorizes or requires can always be called "good," like calling a patient who has already left the Emergency Department to tell him that his radiographs may contain bad news. Therefore, I substitute other words and phrases, so that the whole list looks like this:

1. What is the good or not so good in this situation?
2. What is right or wrong in this situation?
3. What is our responsibility in this situation?
4. What is the proper use of power in this situation?
5. In this situation what is the appropriate relationship of means to ends?

This month's case asks, "When is there a duty to inform?" That makes it similar to the third what-is-the-good question: "What is our responsibility?" The story offers a number of candidate statements about when there might be a duty to inform.

- When there is a patient-physician relationship.
- When uncertainty about the patient's care exceeds some unstated threshold.
- When a provider (or provider-in-preparation) believes she or he sees something that should be brought to the patient's attention.
- When there is no significant risk to the provider or student-provider who has the concern.
- When one feels a responsibility inside oneself. Perhaps when one feels that to live with oneself, to sleep at night, one needs to do something.

Then the question becomes, "Responsibility to whom, to do what?" My answer is, responsibility to assure myself that I have done what was needed to assure that the patient had the information I had, if the patient wanted to have that information.

I distinguish between ethics as what-to-do and why-to-do-it. Because ethics is about action, and health care ethics is about practical service to people, health care ethics easily steers toward what-to-do. As I am not a physician, my what-to-do solution becomes a following thought-experiment:

- I would call the pulmonologist and say that we believe that we have seen bony mets in the patient's ribs.
- I'd ask what the patient knows and understands about his condition.
- I'd ask whether the patient is involved in decision making or whether he has indicated that he wants others to deal with his health care information and decisions.
- I'd say I think the patient or his surrogate needs to know about our finding.
- If the pulmonologist didn't have enough information to satisfy me, I'd ask her or him who the patient's primary care physician was and what she or he knew about the bony mets.
- I'd try to speak to the PCP and I'd repeat the above steps.
- If I couldn't get to the PCP, I'd see whether Mr. Walters was still visiting his daughter and whether he could come in to the hospital for a conference.
- I'm almost done, but perhaps I would take other steps, until I had reached reflective and emotional equilibrium2 about my responsibilities. Reflective and emotional equilibrium means that I continue to entertain all the new thoughts and feelings that I can about the situation, but that none of them prompts any change in my solution.

What-to-do is where health care ethics often stops. When it stops there, it does not think about the ethics rationale (why-to-do-it). The rationale according to my why-to-do reasoning is that when patients come for health care they have a right to know their conditions. Physicians have a responsibility to learn what the patient wishes to know about her or his condition and to satisfy that desire to know. They also have a responsibility to learn how to deliver bad news as well as possible whether they know the patient or not.

Having said all this, I think this story is really about something else: The hidden curriculum in medical school. Dr. Carlson's real curriculum is teaching Scott how to rationalize not informing Mr. Walters.

1. "We can't be calling everyone's doctor all over the country."
2. We don't need to act, because the patient "probably knows already."
3. No follow-up with the patient is necessary.

If this curriculum were spelled out to Dr. Carlson, I doubt he would understand what was being said. The curriculum is most likely hidden more from Dr. Carlson than from Scott and his wife.

In addition, this story is about the fact that ethics is not an add-on. Ethics is built in to everything the health care team does. In that light, Dr. Carlson needs an "ethics kit-bag" that he can carry with him at all times, so that he can help students and house officers address the kind of question that concerns Scott. I can't imagine that Dr. Carlson (or any teaching physician) would address Scott's question by calling an ethics consultant or the ethics committee. That is a feasible approach. But if he isn't going to do that, Dr. Carlson needs an approach to ethics that is

1. practical,
2. portable,
3. flexible, and
4. reliable.

So what should this story be about? To answer that question, let's take a small step back: Medical ethics differs enough from the ethics of everyday life to make the transition to medical ethics long and complex. Scott is in the process of becoming a responsible, self-monitoring professional. Therefore, this story should be about a senior practitioner helping a practitioner-in-preparation learn important differences and overlaps between the ethics of everyday life and medical ethics. He has a responsibility to commend Scott's question and the sensitivity that prompted it. He should ask how Scott is thinking about his responsibility to this patient, how he might carry it out, and where he could responsibly stop. He may even need to talk with Scott about some of the preparation necessary to convey this information to Mr. Walters' doctor(s) and perhaps to Mr. Walters himself.

Dr. Carlson probably has not received the kind of mentoring that Scott needs from him. That's fine. We come by our deficits honestly. And we learn to defend them honestly. So moralizing about Dr. Carlson's teaching lapses with Scott is understandable, but not helpful. Rather, this story is about the obligation of practitioners to teach the ethics of their daily work responsibly or to call in clinically sensitive non-medical ethics professionals to walk students like Scott through their questions. The medical profession does not seem to be there yet. Perhaps non-medical ethics professionals are not even aware of this agenda. So that makes this story about a new direction in medical ethics for the future. This case would be a good place for radiologists to begin learning how to teach some ethics as part of their daily work.

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CASE AND COMMENTARY
Drug Marketing and Patient Consent
Commentary by Erica Ozanne Linden, JD, MPH

Case
Margaret Jacobs has diabetes. She takes medication to control the disease and for the past 5 years has had her prescriptions filled at ABC pharmacy. Last year, ABC implemented a new program to provide health care information to its pharmacy customers. As part of this program, ABC created a customer database that collected information on its customers, including names, addresses, social security numbers, birth dates, and medical and prescription information. In the course of filling her prescriptions, Margaret herself provided ABC with her home address, her social security number, her age, and disclosed that she was diabetic as well as other pertinent medical information. Margaret assumed this information would be kept confidential and at no time was she told why this information was collected.

A few months after the implementation of ABC's new program, Margaret received a letter from ABC discussing the dangers of high cholesterol. The letter informed Margaret that elevated cholesterol is a risk for those people with diabetes and recommended that she take Zilax, a drug used to control high cholesterol. No drugs other than Zilax were recommended for control of cholesterol.

Since the letter was written on the ABC Pharmacy letterhead, Margaret assumed that the letter was in fact from her pharmacy and took it to her primary care physician, Dr. Freeman, to discuss whether she should take Zilax. Dr. Freeman read the letter Margaret brought to him and recognized it as similar to numerous other letters patients had shown him recently. Over the past 2 months, Dr. Freeman had seen at least 15 letters sent to his patients by ABC either warning them of the dangers of certain diseases or urging them to take a specific drug made by a specific pharmaceutical manufacturer.

Dr. Freeman was concerned that the letters sent to his patients encouraged them to take medications that may not be appropriate for their particular circumstances and also wondered why the letters always recommended one brand name drug instead of several drugs that would be equally effective.

Upon further investigation, Dr. Freeman discovered that ABC had been in the news recently for allegedly giving patient prescription records to pharmaceutical companies who then used the information to market their products. Concerned that his patients' confidential medical information may have been given to drug

companies without their knowledge or consent, Dr. Freeman investigated. He discovered that ABC sent out a variety of letters to its customers. The letters took different forms; some gave information about the risks of certain health conditions, some encouraged customers to switch to other prescription medication, and others reminded users of a specific drug to refill their prescriptions.

The mailings were not paid for by ABC but were instead financed by drug manufacturers and a marketing firm was used to carry out the actual mailings. Each manufacturer gave ABC specific selection criteria for each mailing. The criteria were used to identify customers with certain medical conditions, and ABC used its databases to select customers according to the manufacturer's criteria. ABC provided the manufactures and marketing firms with patients' names, addresses, social security numbers, and medical conditions. The information was then used to create the letters that promoted use of drugs manufactured by the sponsoring manufacturer. At no time were ABC customers told of this practice or asked for their consent.

Questions for Discussion

1. Is the practice that ABC Pharmacy is participating in legal?
2. Is the practice ethical? Is it a breach of patient confidentiality? Does the pharmacy need patients' consent before sharing their medical information?
3. Does Dr. Freeman have a legal responsibility to his patients in this case? Does he have an ethical responsibility? What can or should he do to protect his patients from further sharing of their medical information and from unwanted drug marketing?

Erica Ozanne Linden, JD, MPH is a fellow in the AMA Ethics Standards Group.

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IN THE LITERATURE

Untangling "Social" from "Cultural" in Cross-Cultural Medical Education

Rita Mitchell

Green AR, Betancourt JR, Carrillo, JE. Integrating social factors into cross-cultural medical education. *Acad Med*. 2002;77(3):193-197.

In recent years, there has been an increase in the awareness that race and ethnicity affect health outcomes. Despite best efforts to understand the correlation between socioeconomic disparities and poor health outcomes, the problems persist. Medical professionals today face the challenge of caring for patients from many cultures who have different languages, socioeconomic status, and unique ways of understanding illness and health care. Because sociocultural differences between patient and physician can lead to communication and relationship barriers, teaching physicians the concepts and skills that will help overcome these barriers should lead to improved outcomes.

In "Integrating Social Factors into Cross-cultural Medical Education",[1] Alexander Green, Joseph Betancourt, and J. Emilio Carrillo, describe a fundamental component of their cross-cultural curriculum for medical students and residents. Using a patient-based approach to analyze factors that correspond to negative outcomes in health, the authors advocate a "social review of systems" that emphasizes key social barriers to the delivery of effective health care.

The authors point out that, while medical education at all levels has begun to adapt to the challenges of diversity in health care, this new cross-cultural medical education pays little attention to social factors that may be the greatest barrier to successful health outcomes. Acknowledging that the usual predictors of socioeconomic status such as income and education are typically addressed, the authors charge that illiteracy, immigration experiences, religion, social stressors, and social support networks—each of which has an impact on health—are generally ignored in cultural competency courses.

The authors believe that "the brief and perfunctory social history that has become acceptable in medicine leaves physicians ill prepared to deal with the complex ways in which social factors can affect the medical encounter".[2] Moreover, they maintain that, by teaching doctors-in-training to view culture as the explanation for what are essentially social issues, the medical community risks inadvertently stereotyping various cultural groups as poor and undereducated. The authors believe this risk can be minimized if doctors-in-training are sensitive to the patient's social context,

know how to explore relevant social factors that cut across cultures, and use what they learn to provide better care.

To aid in the understanding of social factors, the authors have constructed a social context review along four domains (social stressors and support networks, changes in environment, life control, and literacy), each of which they think receives too little attention in traditional medical education. The authors suggest thinking of the questions and interview tools for each of the domains as a social "review of systems" similar to the traditional review of organ systems. The social context review of systems questions should be highly selective and focused specifically on issues pertinent to the individual patient. A primary goal of the social context systems review is that physicians recognize factors that can compromise treatment plans and work with patients to minimize the adverse effects of those factors. Medical care given in this way will foster trust, enhance communication, and improve outcomes.

Physicians can provide an important source of counseling and support, but the authors argue that it is usually beyond the scope of the physician's role to solve the difficult issues of social stress or lack of a support system. A critical element is the ability of the physician to recognize key problems, assess their effects on the patient's health and the medical encounter, and help the patient to develop his or her own social supports and other potential methods of dealing with medical and social issues. The authors suggest the adoption of a "biopsychosocial" approach to these issues. Doing so will prevent "medicalization of fundamentally social problems" which in turn will avoid potentially costly work-ups and treatments.

Questions for Discussion

1. Can "cultural competence" be taught? Should medical schools be concerned with cross-cultural education and producing physicians who are attuned to cultural differences of patients?
2. Given the realities of medical practice, is it reasonable to ask physicians to assess patients' social context? Who might physicians rely on to assist patients in developing their social support networks? How could such services be billed and paid for?
3. Is cultural competence a necessary condition for trust between patient and physician?

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MEDICAL EDUCATION

Justice in Residency Placement

Timothy Murphy, PhD

Residency training is an essential component of medical education and is required in most jurisdictions for licensure as an independent medical practitioner. In the United States, the match system assigns approximately 23,000 applicants to residency training programs in the areas of pediatrics, obstetrics and gynecology, internal medicine, and the rest. The system has been in place since 1952 and is overseen by the National Residency Match Program, a non-profit organization. Rank order lists are at the heart of the match. An applicant picks a number of residency programs and ranks them according to preference. The residency program prepares a similar list, ranking the candidates it most wants in its program. A computer program compares the rankings and makes assignments according to a certain algorithm. These assignments are then announced to all parties on specific days. This system is effective in a number of ways. First of all, it standardizes the timetable for decisions, and applicants are in no position to tie up offers while waiting to hear from another institution. Institutions are not held captive either in making assignments while waiting to hear from particular parties.

A bioethicist at Mercer University, D. Micah Hester, has recently argued that the match system is incompatible with the core values of medicine.[1] Hester's chief criticism is that current match program embodies a competitiveness that corrupts core values in medicine. According to Hester the competition involved in the match encourages values that are antithetical to the medical profession. He says that "so long as competitive practices run rampant in institutionalized activities such as residency matching, medicine simply will never fully meet the concerns of the people who need its help and a society that needs its comfort."[2] In short, medicine is hyper-competitive, the match is part of this syndrome, and we all suffer as a result.

Hester proposes an alternative to the match as it currently exists: random assignment. Under his proposal, all candidates would stand an equal chance of being selected for each residency opening in a designated discipline. For example, each candidate interested in a pediatrics residency would be assigned at random to one of the available slots in pediatrics residencies around the country. There would be no rank order lists and no communication between candidates and institutions. This approach would—as Hester does not fail to note—eliminate personal choice altogether. In addition to curbing the competition involved in jockeying for candidates and positions, Hester says this approach would free up new resources and energies: "Eliminating the competitive match system would provide residency

programs and candidates with the resources to work on other more pressing issues. More time, energy, and money could go to support such concerns and activities as better salaries and hours for residents, outreach programs, deeper professionalism, and ethics and humanities education—concerns and activities that go to the heart of moral medical care."[3]

This is a drastic proposal and, I think, unwarranted both in terms of damaging effects on residency programs and the undermining of personal choice.

Medical residencies are not equal in terms of what they prepare their residents to do and how well they achieve their goals. There is a social division of labor in terms of what residencies are training their physicians to do, and they are not interchangeable replicas of one another. Some residencies are much more likely than others to encourage their trainees to engage in clinical research, to assume academic posts, and to go on to leadership roles in the profession. Others are much more likely to channel their trainees into certain kinds of practice, for example, working in institutions that provide large amounts of charitable care. It *does* matter which students are tracked into residencies because these programs train particular people whose knowledge and skills are fundamental to the design of the health care system, produce trainees who are expert in the management of certain kinds of patients, and develop the skills of particular people who will fill specific roles in the delivery of health care. It is reasonable to believe that random assignment of residents would undercut this division of labor and compromise the ability of residencies to achieve their important social goals.

When it comes to the fate of residents themselves, there are important reasons to avoid complete randomness in residency assignment. For example, many residents are married and have children. Some residents have primary responsibility as caregivers for aging or sickly parents. It would be a fundamental hardship to say that these residents should have no say whatsoever in where they train. A decision to pursue a particular residency is *not only* about where one continues medical education; it also reflects choices about one's familial and financial interests. For some residents it would be a hardship in the extreme to move their families from Florida to Alaska or to relocate them to rural programs far from their families. In another instance, it would be an undue economic hardship to ask some residents to shoulder the unwanted costs of residency in Manhattan when they actually prefer less costly living in a smaller city in the South. These kinds of complications could be multiplied without much difficulty. That some residencies last 6 and 7 years makes it all the more important to recognize that random assignment in residency could create and magnify all kinds of problems for trainees.

Hester does acknowledge that some residents would be resentful about assignments given to them by chance, but he thinks that this resentment would be offset by the value of being exposed to trainees from all across the country. He says that residency programs with their supply of trainees chosen at random "would benefit from having fully supplied medical staffs and residents from an array of educational

backgrounds, and the diverse residents could learn from each other while providing care for otherwise underserved patients. On the flip side of the equation, if it is in fact the case that some residency programs are better than others, these so-called "top" programs would have the opportunity to work with a variety of residents from different schools and backgrounds, residents who might not otherwise have had the opportunity to learn from the "best." In response, it must be said that it is not clear how random assignment would necessarily improve care for underserved patients. A lottery might help distribute talent more broadly across residencies, but by itself this would not mean that underserved patients would necessarily receive better care. If "the best" medical graduates do not like their placement, lingering resentment could work to sabotage quality of patient care they deliver as residents.

Hester goes on to compare his proposal for random assignment to the kind of drafting that occurs in professional sports. Many professional athletes are assigned to teams without their having a say in the matter—and their families and living preferences are not taken into consideration. Hester wonders why this same attitude—it is enough for small town heroes to play in the National Football League no matter where they end up—she should not also prevail in medicine. In other words, the rewards of being in medicine should override any specific concerns about where one wants to live and train. It is not clear, however, that random assignment would promote selfless values in physicians any more than it does in professional football recruits. Random assignment would undoubtedly disrupt important interests for more than a few residents—which disruption could easily undermine selfless attitudes. Moreover, it is certainly not clear that random assignment would make trainees better diagnosticians, better therapists, or even help them exhibit more humane behaviors toward patients. Simmering resentment could corrode humane values and foster poor clinical habits just as badly—if not more so—than the competitive aspects of the match. Even professional football players—the best of them anyway—try to control where they play, especially those concerned with the rewards of league victories, championship rings, and commercial endorsements.

Over and above the effect random assignment would have on residents, a lottery system could also be expected to undercut motive and effort among medical students. Certain medical school graduates are better than others with regard to their capacities in diagnostics, in therapeutic judgments, and interpersonal skills. It is to be wondered what incentive there would be for medical students to strive toward superior achievement if residency assignment turned a blind eye toward *all* accomplishment and occurred only by chance. It might well be true that some students would go the extra mile in medical school, those who do so for personal satisfaction or some other intrinsic reward. However, it is hard to believe that performance would not suffer if extra efforts *could not, could never* help in securing a preferred residency. And, to continue the theme of performance for a moment, it is hard to see that one would be doing the poorest performing students any favor by placing them in the most demanding residencies in the nation. By extension, it would be doing little favor to burden highly functional residencies with applicants

who have done little more than stumble and limp their way to a diploma. After all, it is not only talent that would be randomly distribute, a lottery would distribute the opposite of talent—whatever one wants to call that—as well.

Hester does acknowledge that random assignment would mean the loss of personal choice, but he believes this loss is acceptable because of the way in which residency competition would be undercut. It is simply untrue, of course, that once some resources are freed up that these would flow automatically to more noble causes. For example, physicians involved in overseeing residency recruitment—interviews, answering questions, preparing promotional materials, ranking candidates—might just as easily turn their attention to clinical revenue as to improving humanistic education of residents.

Lastly, there is also an important difficulty in Hester's claim that the match operates in a way that is inconsistent with the core values of medicine. The preservation of choice is one core value in medicine, one that undergirds patient-physician encounters. The American Medical Association Principles of Medical Ethics asserts that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."[4] In other words, *choice* is a core value of medicine because it is important to both patient and physician alike to enter into mutually satisfactory relationships. To put it another way, except for emergency or court-ordered treatment, health care relationships should not be *random or involuntary*. It is hard to understand why this principle—so important to health care relationships—should not also extend to educational relationships.

In one study of residency applicants, only 4 percent of the respondents believed that the match should be completely overhauled.[5] Whatever the problems of the match system are, it is not clear that residency assignments made at random will solve them without also causing broad, systemic problems on a large scale. It is one thing to dream of medicine that is shorn of the worst effects of competition and that is fully committed to ethics, professionalism, and humanities. There is no reason, though, to think that a lottery system would help achieve these goals in any meaningful way. There is no obvious reason to think that revolution rather than reform should be the appropriate response to problems in the match.

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VIEWPOINT

Folk Remedies

Rita Mitchell

Sickness was so common in frontier life that many diseases were not even regarded as such. Many a frontiersman suffering from malaria was so used to it that he did not consider himself sick.

An 1837 cookbook, which contained many remedy recipes, advised *against* calling a doctor except for smallpox, "inflammation of the bowels," nosebleed and "gravel" (kidney stone). The recipe for kidney stone: Juice of horse-radish made into thin syrup, mixed with sugar; a spoonful every four hours.[1]

Other remedies and their recipes included:

- *To cure a toothache*, pick the tooth with a coffin nail, the middle toe of an owl, a needle used to make a shroud, or a splinter from a tree struck by lightening; apply the juice of the "toothache plant" (prickly ash), pack the tooth with cotton soaked in oil of cloves, rub it with sumac (poison oak) gum; then chew the root of a thistle.

- For arthritis, more popularly—or unpopularly—known as "rheumatiz, carry buckshot or a buckeye in your pocket; take the powdered ashes of a turtle shell, internally; chew a thistle root; carry a peeled potato in your pocket until it turns black; wear shoes with copper nails to ground the pain; wear copper bracelets; or rub the joints with snake oil.

- Teas and other "decoctions" were common remedies for fever and chills: make a tea of the ground bark of the wild snowball (red root), the bark of the wafer (stinking) ash, the leaves of the sourwood (lily-of-the-valley) tree, the common chickweed, the leaves of sheep sorrel, the scarlet sumac bark (ole poison oak, again) or red pepper. One could also treat chills and fever by chewing turnip root, eating watermelon or grapes; or putting black pepper in one's stockings.

- Coughs and colds naturally called for a multitude of "cures": passing the sick child three times under a horse's belly; administering kerosene, internally, with or without sugar, putting a strip of raw pork or one of red flannel or a dirty scarf around the neck.

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VIEWPOINT

The Trend Toward Casual Dress and Address in the Medical Profession

Kayhan Parsi, JD, PhD and Sara Taub, MA

Your brand-new family doctor walks into the waiting room, spots you, and hurries over to introduce himself. He slaps you cheerfully on the shoulder and then booms: "Hiya, Bob! I'm Dr. Hotchkiss! What's up?"

One of the more enduring changes of the "dotcom" revolution of the 1990s is the movement toward casual dress in the workplace. Suits and ties are out. Polo shirts and khakis are in. Ninety percent of US companies allow some form of casual dress, up from 62 percent in 1992.[1] Traditionally staid employers such as law firms and banks are enthusiastically jumping on the casual bandwagon, though some still require formal attire for interactions with clients. Employers argue that it is a perk that improves worker morale, yet costs nothing.

This "casualization" in the workforce is but one component of a larger cultural trend in which social relations and forms of address are less formal than they were a generation ago. Adult peers typically dispense with formal titles of address (eg, Mr. or Ms.) and move directly to a more familiar first-name basis. This may reflect a certain democratization. It also may reflect the influence of youth culture, where informality and spontaneity are greatly prized.

Is society better off with more formal or informal styles of dress and address? Is this an ethical issue or one of mere etiquette? Does what we think of as "mere etiquette" have some ethical significance? Consider the opening scenario. Is the physician's etiquette likely to affect the therapeutic relationship?

Casualization has indeed influenced dress and behavior within the health care arena. Nurses long ago shed the white uniform and cap for more practical and comfortable garb. Certain television shows, such as *ER*, have helped popularize the loose-fitting surgical scrub as the uniform *de rigueur* in medicine. Some places, however, attempt to draw the line in casualization. One academic medical center reinforces the notion that casual dress may not be in the best interest of the patient-physician relationship:

A physician's appearance serves as a powerful, nonverbal symbol that affects communication between doctor and patient. Patients react negatively to jeans, athletic shoes and socks, scrub suits, clogs, prominent ruffles, dangling earrings,

and excessive aftershave lotion or perfume. Patients express preference for well-trimmed hairstyles.[2]

Physicians have mixed responses to these matters, as exemplified in an exchange of letters in the *Newsletter* for the American Society of Anesthesiologists.[3] One physician claimed, "You have to 'talk the talk,' 'walk the walk' and 'dress the dress' if you want to be recognized as a physician." Another stated, "When it comes to our attire, anesthesiologists need to stop being so egocentric: we dress for our patients and for the professionals with whom we work, not for ourselves." And a third added, "How many times has the perception that we are slobs affected interactions with the public, other physicians, hospital administrators and health care organizations?" But a dissenting voice felt that "[n]o amount of gaudy, expensive dress will ever make some anesthesiologists professional. . . . [A] physician can act professionally regardless of what he or she is wearing."

The effect of dress on patients was studied by physician researchers at West Virginia University. Dr. Dorian Williams, associate professor in the Department of Family Medicine, led a study in which they surveyed 209 patients, 62 medical students, 63 residents and 109 faculty members. Dr. Williams hypothesized that patients wanted a more professional look among residents, and his study tended to prove him right. Even more interesting, physicians and patients alike favored white coats and name tags. Nonetheless, Dr. Williams argues that a physician's specialty and the length of the patient-physician relationship matter. "In psychiatry you can overdo it too. In anesthesiology . . . a scrub suit works fine. If you are a community-based doctor and your patients know you, casual dress may be OK. But certainly if you don't have an established relationship with the patient and you are working for someone else, representing their institution, the patients want the doctor to look professional," he said.[4]

More recently, two California dermatologists reported on their survey of 275 patients. More than 33 percent voted against sandals, clogs, and blue jeans for both men and women and against earrings, open shirts and long hair or ponytails on men. Twenty-five percent preferred traditional hairstyles for men and women and disliked surgical scrubs and cologne for male doctors.[5]

The perspectives represented in these comments points to the larger question: Does casualization compromise the therapeutic relationship? There are those who argue that physicians' professional attire and behavior play an instrumental role in their communication with patients, inspiring confidence and credulity and indicating respect and a desire to please. If this is indeed the case, casualization may indicate a significant change in how physicians choose to relate to their patients—one that could have consequences for patient care and deserves to be studied further. On the other side of the debate are individuals who claim appearance and attitude are mere matters of social etiquette. They insist that a physician's medical abilities are what really matters; questions of dress and address are frivolous criteria by which to judge a professional responsible for promoting medical well-being.

Whether casualization in the doctor-patient interaction is one-sided or reciprocal may color general reactions to the trend. If the relaxing of social etiquette norms is exercised only by physicians, it could reinforce the power differential that already exists between patient and physician, rather than foster a more comfortable environment for all. Although the white coat worn by physicians has long been criticized as a symbol of power that skews the medical encounter, Williams' study seems to suggest that patients appreciate seeing physicians wearing it. This reflects the fact that non-professionals expect professionals to don certain kinds of uniforms in order to contextualize the relationship and give it the gravity and respect it deserves. For instance, seeing a judge in street clothes rather than judicial robes would probably send the wrong message to litigants—that the judge is just another person who does not have special duties with regard to the proceedings. These social expectations and psychological responses are evoked by other professional uniforms, whether they are worn by police officers, members of the military, or clergy. The style and formality of the dress set the relationship apart from ordinary business encounters, reminding physicians of their professional obligation and reinforcing the patient's confidence in the individual clinician who, as denoted by his or her attire, is a designated representative of a trusted profession.

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PERSONAL NARRATIVE

Through the Student's Eyes: Why Are You Here?

Dragan Gastevski

Part II of a premed student's reflection on the aging and increasing disability of his grandfather, proud founder of a Macedonian village, freedom fighter, and immigrant to America.

With the aggressive schedule of exams behind me, I enjoyed one relaxing weekend away from school at home with my family. I closed my eyes and let my tired back sink into the leather chair. The gentle hum of the television seemed to be my only companion for the moment. Suddenly, I felt a loud moan perfuse the tranquility of the room. My eyes popped open and my head quickly swiveled to my left. I saw that I had a guest.

My grandfather, Pando, was trying to get up from his slumber on the couch adjacent to me. His moaning was characteristic of a man not exactly aware of his surroundings. I had noticed that he would sleep during the day due to his inactivity. It became immediately apparent, however, that something was wrong here. Pando tried to rotate his torso so that he could sit up. I saw his hands slide across the pillows several times as his head lurched back to the pillow. Eventually, his body rose to stand erect. He leaned ahead in an attempt to get up. I began to realize that he had to go to the bathroom. He heaved his body forward while squeezing the couch cushion with his hands. During the next few attempts, I noticed that his muscles were not able to lift his body. He would, eyes squinting with pain, raise himself so close to his goal. His muscles would then give out sending him straight back down to that cursed cushion. Three attempts later, Pando was on his feet, staggering around the couch. His knees wobbled left and right with each placement of his cane. I listened to that characteristic tap-tap-tap, not knowing whether he would make it in time.

Ten years ago, this would have been no problem for Pando. When I was a child, I remember my mighty grandfather coming home from work exhausted. He only needed one look at my face to convince him to toss his bag through the door and set off on a mission to get me some of my favorite restaurant food. Together, we were like one. We would go on field trips to museums and the park. Whenever I would tire, he would grab me with his enormous arms and hurl me up to his shoulders for the rest of the trip. Yes, this man would laugh in the face of pain, having spent 2 years in a Nazi death camp in his youth. The medical difficulties he was

experiencing 10 years ago were not entirely unwelcome reminders of the excruciating pain and extreme suffering he experienced in his early years of manhood.

Today my grandfather suffers from immense pain associated with arthritis, diabetes, and myriad related diseases. His doctors prescribe certain medications and treatments knowing that, though they are difficult today, they will have a large positive impact on his future. After Pando's toe amputation surgery, his doctor ordered home physical therapy. Pando told the doctor that he understood what was asked of him. To my eyes, it appears that the doctor must have ordered sleep! Why is it that Pando does not follow what the doctor has ordered? Whenever I am home, he takes out his green exercise rubber band, attaches it to the appropriate foot, and begins his exercise. "See," he says in his broken English, "I work really hard!" I watch and congratulate him on his efforts, thinking that this is the way he lives everyday of his life, regardless of my presence. As I walk away from "his couch" and proceed into the kitchen, I notice his efforts diminishing. Pretending to take no notice, I continue building my sandwich. I put the pickle jar back into the refrigerator and close the door, uncovering a completely different scene in the living room: My grandfather is facing away from me but obviously sleeping. He has dozed off, letting his feet rest on the floor, rubber band and all.

At the next office visit, the doctor asks, "Pando, are you doing your exercises?" "Yes," he says, "My grandson sees me!" The effort to back up his statement is futile; the doctor sees there is negative progress in the muscular development of his thighs. "You know, Pando, you won't be able to get around the house unless you do these exercises," prompts the doctor. "Ya," Pando immediately replies with an air of guilt in his eyes, "I get roun' no problem in da hous." The doctor forces a smile but realizes that his attempts to convince Pando to exercise are also futile. He goes through the routine one more time, mechanically emphasizing the steps of each exercise, and sends us home. I leave with Pando feeling even guiltier than he; I know he will do the same thing he always does.

It is one thing to order a 5-year-old to pick up his toys, and another thing to order this aging head of a dynasty to do his exercises. The 5-year-old, however, will ignore your orders for the same reason the grandfather does: just because he doesn't want to do the task. If something does not bring pleasure to a person's life, why should he do it? Doctors and family will argue that it is the greater good that is desired. Temporary pain and discomfort caused by exercise and other prescriptions will eventually lead to a higher overall level of happiness. This may be a valid argument for the 5-year-old, but in truth, it is not valid for Pando. Perhaps the pleasure derived from much needed relaxation is far greater than the pleasure he would reach after doing many grueling exercises. On the other hand, it is also difficult to sit in my leather chair and watch my grandfather live the remaining years of his life, not knowing whether he will make it to the bathroom. Pando once told me an old Macedonian anecdote. "Dragan," he said in his native tongue, "the

old are like children. We think and act as if we are going backwards through the stages of maturity." How very true, I immediately thought.

Non-compliance is a serious issue that can be due to difficulties in language, intelligence, or mental disposition. In this case, Pando, with his pre-medical student interpreter, has no reason except his mental state to not comply with the doctor's orders. And unfortunately, some doctors will sever the relationship if visits don't progress toward results. In one case, Pando's endocrinologist asked him how the prescribed insulin was working for him. My grandfather replied, "I don' take insulin. I take pills." The specialist bluntly replied, "Then why are you here? What more can I do for you if you don't do what I tell you." Pando now sees a different endocrinologist. It is fair to say that billing Medicare for appointments that yield nothing but small talk seems nonsensical. Interpreters are provided to overcome language difficulties, and guardians are appointed for those with less than the required intelligence. But what can doctors do for those patients that just won't follow orders for whatever reason they see fit? After all, the patient-physician relationship hinges on the patient's desire to do what is necessary in order to be helped.

Part I of Dragan Gastevski's reflection on his grandfather appeared in *Virtual Mentor* in March 2002.

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