

*Virtual Mentor*  
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# Virtual Mentor

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## FROM THE EDITOR

### Healing Narrative—Ethics and Writing about Patients

As Jack Coulehan and Anne Hawkins put it, “writing about patients is a growth industry” [1]. Recent years have seen an explosion of both fiction and nonfiction works written by physicians for a popular audience. Atul Gawande’s *Complications*, Pauline Chen’s *Final Exam*, and Danielle Ofri’s *Singular Intimacies*, all critically acclaimed and widely read, open a window into an experience that was once the sole province of those in medical training. These authors employ patient stories to convey poignant insights about what it is like to practice medicine. Neurologist Oliver Sacks’s classic *Awakenings* and more recent *An Anthropologist on Mars* also make use of patient stories, guiding his readers into the awe-inspiring world of the human mind through the unusual experiences of his patients. These powerful memoirs, however, move us to ask, whose stories are they telling? What are physicians’ responsibilities towards patients when they put them on paper? In this issue of *Virtual Mentor*, we explore the ethics of writing about patients and examine the sometimes conflicting, sometimes synergistic duties of physician and author.

Sharing patient stories has always been a mainstay of medical education—every issue of *Virtual Mentor* begins with three clinical cases. This is not an arbitrary quirk but a reflection of a long tradition. Clinicians share patient stories on the wards, in grand rounds, in doctors’ lounges; they tell patient stories to medical trainees and teach them the language in which to tell these stories themselves. Case reports have long been an important tool in the academic medical journal as a way to expose other physicians to unique, exemplary, or otherwise useful patient cases. For this reason, our first case starts on familiar ground: what are the ethical considerations involved in publishing a patient case in an academic journal? Ronald Pies and Judy Kantrowitz address the tension inherent between the duty to further therapeutic knowledge and the need to protect patient confidentiality. Although there was a time when the likelihood that patients and those who knew them would access medical journals was vanishingly small, in the age of Google and PubMed this is no longer the case. The casual process of disguising names may no longer offer enough protection. Clinicians must decide how to request permission to publish a patient’s case or learn to thoughtfully and systematically de-identify patients. What new elements could this introduce into the patient-doctor relationship?

Physicians write about patients in other familiar ways. Thomas Robey, in this month’s clinical pearl, looks at the humble medical record. Even the everyday activity of composing patient notes is an act of representation. A good note can communicate volumes to the next clinician who sees the patient, and how we represent a patient in the record has the power to materially shape future treatment.

Robey describes the value to students of keeping a patient journal during medical training to remind them of the patients that impacted them the most.

The narrative medicine movement in medical education places a similar emphasis on encouraging students to engage with patient stories and the roles they play within them. By guiding students to apply narrative techniques to the patient's life story, educators like Johanna Shapiro and her colleagues hope to encourage medical students' "moral imagination" and help them become empathic clinicians. Martin Kohn, his fellow educators, and students find an equally creative way to present and re-present students' stories, establishing a "reflective moral community" and helping them gain insight into their medical training experience.

Narrative medicine teaches us how storytelling can be a vehicle for ethical thinking, but what about the ethics of storytelling itself? In his commentary on this month's second clinical case Jack Coulehan addresses physician authorship of a memoir intended for a public audience. Patient confidentiality, he argues, has been a core value in medicine, embedded in Hippocratic tradition as well as in more contemporary concepts of patient autonomy and self-determination. How can physicians write and publish patient stories and still respect these ethical boundaries? In the genre of "creative nonfiction" in which many contemporary physician authors write, this is uncertain ground.

Just like physicians who publish in professional journals, popular physician-authors may also be expected to live up to a certain standard of truth. Often physician writers change, merge, or otherwise de-identify individuals, opting for "story-truth" over "what-happened truth," to borrow the distinctions of writer Tim O'Brien [2]. This can be problematic for the authorial obligation of "keeping faith with the reader" [3], unless the author "lets [the audience] in on the secret." Sometimes, however, physicians can treat in writing what they can't treat in the clinic. Patient stories as narratives of personal struggles, loss, and triumph can have enormous power. In making these stories public, physicians can harness this narrative power to raise awareness of health issues that can only be solved at a community or policy level.

In a purely nonfiction format such as journalism, expectations of truth are radically different than they are in a memoir. What in one format is perfectly appropriate storytelling license is highly problematic in another. This standard of factual truth places special demands on physicians who are also health journalists working for newspapers or media networks. In this month's policy forum, Tom Linden writes about the balance physician-journalists must achieve between two binding codes of ethics that can sometimes appear to be in conflict. On the one hand lies concern for the patient and the delicate line between the reporter-subject and doctor-patient relationships, on the other, a dedication to obtaining and disseminating factual information.

Sometimes a work that presents itself as pure fiction can make as dramatic an impact as journalistic truth. Howard Brody, in this month's medical narrative feature looks

at what has arguably been one of the most controversial novels about the medical profession, Samuel Shem's searing 1978 satire of American residency training *The House of God*. Loosely based on the author's own experience, the novel was a bestseller among residents—while infuriating attendings—and did its part to influence later reforms in residency training. How, Brody asks, has training changed in the last 30 years, and how has it stayed the same? In this month's journal discussion, Angeline Wang looks at how cardiologist John Stone evokes, through the medium of poetry, certain emotional truths of illness and doctoring that would perhaps be inaccessible in any other format.

Writing about patients is not a new enterprise. William Carlos Williams, a general physician practicing in New Jersey, became one of the leading American poets of the twentieth century; Anton Chekhov, the late nineteenth-century Russian dramatist and short story writer, also drew on his medical experience [4, 5]. In today's world, writing about patients is no longer the sole province of physicians with particular literary (and time-management) talent. Blogs by physicians, medical students, and other health professionals number in the thousands [6]. As Bryan Vartabedian, Jay Baruch, and Emily Amos point out in their commentaries on this issue's third case, many of the challenges faced by physicians communicating through blogs and other social media are unique to the immediacy and accessibility of online communications, but many are not. Considerations of confidentiality and representation are the same whether a physician publishes in a traditional print format with the benefit of an editor or self-publishes on the Internet. Physician activity on blogs and social media often brings up questions of professionalism. Just as in print media, even when physicians do not represent patients' stories, they do represent themselves and, many argue, the medical profession overall. As the commentators point out, however, the responsibility can cut both ways. Immature or injudicious comments can do damage to patients, colleagues, and the profession as a whole. However, by providing an open forum for discussion and disseminating quality medical information, physician blogs can have the opposite effect. Do physicians as a group perhaps have an obligation to expand their online presence? The increasing urgency of these questions has prompted responses from professional organizations, for example the AMA's 2011 policy on professionalism in social media, this month's opinion in "the code says" section.

Writing in the *Lancet*, Faith McClellan draws a parallel between the physician's clinical gaze and the writer's sensibility. Both, she remarks, "are engaged in an often complex process of identification with and detachment from their subjects—close enough for compassion, distanced enough for critique" [7]. In examining the ethical and practical issues intertwined in the clinician-writer's enterprise, outside perspectives can provide that critical distance. In this month's op-ed G. Thomas Couser examines the patient's perspective: even when a clinician follows all of the standard ethical guidelines, there is still a potential for "delayed iatrogenic pain" when the patient later reads about him- or herself. For this reason, Couser advocates careful moral reflection from the clinician: even when the patient gives permission, would he or she be disturbed to find his or her own story in an "alien discourse"?

In this month's medicine and society feature, Susan Sample shifts the focus from physician-writers' portrayal of patients and their vulnerabilities to how the writers portray their own. Critics and readers expect physician-authors trading in such personal and emotional capital to be likewise emotionally invested in what they write, to speak from a "threshold of vulnerability" that makes their humanity accessible to readers. Valarie Blake explores yet another perspective in the health law section. Although societal expectations encourage openness from physicians who write and publish, the legal system sometimes takes a different view.

As physician and bioethicist Edmund Pellegrino puts it, literature and medicine "are ways of looking at man and both are, at heart, moral enterprises. Both must start by seeing life bare, without averting their gaze" [8]. In this light, the confluence of writing, medicine, and ethical reflection we see from so many angles throughout this issue of *Virtual Mentor* is not at all coincidental. Only a small number of physicians have the time, talent, or inclination to write professionally, but all physicians are in some way engaged in a narrative enterprise. In small, everyday ways physicians engage in acts of representation when they share patient stories, and it is frequently through stories of patients that we perpetuate the ethical core of our profession. The advent of narrative medicine in medical education, the clinician presence in social media, and the expanding number of physician memoirs urge us to find contemporary solutions to timeless issues and remind us that we should handle the bodies and the stories of our patients with equal care.

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## CLINICAL CASE

### Case Studies and the Therapeutic Relationship

Commentary by Ronald Pies, MD, and Judy L. Kantrowitz, PhD

Dr. Zhou is a psychiatry resident finishing her second year at an academic medical center in a university town. One of her first continuity clinic patients, Teresa, the 15-year-old-daughter of a university staff member, was referred to the clinic after her family's insurance coverage changed and she needed a new mental health provider. According to the records from her prior psychiatrist, Teresa had been diagnosed with bipolar disorder. Despite several courses of pharmacotherapy, however, she has continued to struggle with mood symptoms and is still doing poorly in school. Dr. Zhou focused her first few meetings on building a good rapport, and eventually Teresa confided in her that she had been using various drugs with her friends. Addressing substance abuse became a part of Teresa's treatment. After a year's work together, Dr. Zhou felt that Teresa had made a good amount of improvement.

When Dr. Zhou presents Teresa's progress to her attending physician, he remarks that she has been doing very well managing a complex case. Recalling that Dr. Zhou had mentioned the possibility of applying for a fellowship in child and adolescent psychiatry, he suggests that she look into writing up Teresa's case and submitting it to a professional journal. Distinguishing between bipolar disorder and substance-induced mood disorder can be very difficult even for an experienced psychiatrist, he tells her. Not only is this a good case study, he adds, but a peer-reviewed journal publication would look good on her upcoming application.

Dr. Zhou writes up the case, but returns to her attending physician, uncertain. "What are the rules about getting permission from the patient when you publish their case study?" she asks. "Just make sure you've changed her name and de-identified her," he tells her. "That's all I have usually had to do." Her other clinical mentor disagrees. "Lots of the journals are changing their policies," she says, "and many of them would expect you to ask Teresa and maybe her parents for their consent, then have them read the draft over before you send it in." Dr. Zhou is concerned about how she should proceed. She doesn't think Teresa would necessarily mind being written about, but she wonders if that information will change her dynamic with the patient.

### Commentary 1

by Ronald Pies, MD

Clinicians have been writing about their patients (or clients) for more than a century. Indeed, Sigmund Freud maintained that psychoanalysts have an affirmative *duty* to

publish what they learn from treating patients [1]. In publishing his case history of “Dora” in 1905, Freud took several steps to conceal the patient’s identity; nevertheless, Dora’s identity was eventually discovered.

The case of “Teresa” raises many ethical questions and dilemmas with respect to publication of clinical case reports. What are the physician’s fiduciary responsibilities to the patient? How should physicians weigh their duty to protect the patient’s privacy against their well-recognized responsibility to share their clinical experience and to educate colleagues? If physicians routinely seek the patient’s permission to publish case studies, must they also allow patients the “right to revise or reject” the case write-up? How do the specific concerns in treating children and adolescents affect these decisions?

### **General Ethical Implications of Case Reports**

Among the many ethical considerations in publishing clinical cases are the following: (1) preserving *confidentiality*—that is, protecting the patient’s right to privacy; (2) fulfilling the physician’s *pedagogical responsibilities*; (3) adhering to the principle of nonmaleficence, which entails avoiding any action that may harm the patient; and (4) respecting the potential *ownership rights* of the patient to written material that pertains to his or her care [2].

In truth, it is not clear precisely what clinical material physicians are required to keep “confidential.” On the one hand, *information contained in the medical record belongs to the patient* and, absent a subpoena or other compelling legal authorization, cannot be released to third parties who are not directly involved in the patient’s care without the patient’s explicit consent [2, 3]. On the other hand, it is not clear that physicians are ethically required to subject written accounts *of their own clinical experiences* to a “prior restraint” process governed by the patient’s preferences. Thus, the *physician’s narrative*—whether a case study, an essay, or a poem—is arguably the intellectual or artistic work product *of the physician*. In this view, so long as adequate measures are taken to disguise the identity of the patient, the physician has no obligation to obtain the patient’s permission to publish the case material. Indeed, any putative “right” of the patient to approve or edit such material creates potential barriers to the unfettered transmission of medical knowledge. Nonetheless, the principle of nonmaleficence may impose certain constraints on what the physician may publish, sometimes superseding the physician’s pedagogical responsibilities and prerogatives [2, 3].

### **Risks to the Therapeutic Alliance**

One can easily understand, in this age of Google and Facebook, that some patients may seek out and discover professional articles written by their physicians. A patient who recognizes himself or herself in the physician’s case report may react with anger, dismay, or confusion if not adequately prepared for this event. Some medical writers will seek more informal “assent” on the patient’s part, without going through a formal consent procedure. I have generally published case material relating to *former* patients treated many years ago without attempting to “track them down” or

obtain informed consent in such cases. Not all colleagues would agree with this approach, and omitting informed consent clearly raises the threshold for disguising the case material and protecting the patient's confidentiality.

Finally, even though the patient's informed consent may protect the author and the journal, it may fail to protect the patient from an adverse outcome if, for example, a reader is able to identify the patient from the written report and uses this information against the patient's interests. Clearly, such an outcome could be devastating to the therapeutic alliance and could create serious legal problems for the physician.

### **Is Obtaining Informed Consent Always in the Patient's Best Interest?**

Notwithstanding such risks, one perspective argues that the very act of obtaining the patient's permission to publish may sometimes be harmful—and even unethical. With respect to patients still in treatment, Levine and Stagno [4] argue that asking the patient's permission to publish *crosses a professional boundary*; i.e., it inappropriately inserts the doctor's personal and professional agenda into the patient's treatment. Dealing with the physician's agenda may consume the patient's time and energy, and, on this view, risks transforming a treatment session into an adversarial discussion of the physician's personal or professional goals.

Furthermore, the very concept of informed consent may be dubious when it comes to obtaining a patient's consent to publish. After all, a patient in treatment might reason, "If I don't give Dr. Jones permission to write up my case, she might not like me anymore—maybe she'll even stop seeing me." Given the asymmetric power relationship in the patient-physician dyad, the notion of truly informed consent—freely and autonomously provided—is at least open to question.

### **Journal Policies on Case Reports**

The editorial policies of professional journals reflect a wide range of concern about privacy in clinical case reports [4]. For example, one prominent journal, the *American Journal of Psychiatry*, has a very succinct and generalized requirement, under the rubric of "patient anonymity":

Ethical and legal considerations require careful attention to the protection of a patient's anonymity in case reports and elsewhere. Identifying information such as names, initials, hospital numbers, and dates must be avoided. Also, authors should disguise identifying information when discussing patients' characteristics and personal history [5].

In recent years, however, there has been a trend toward more stringent consent requirements, as typified by these instructions from the *British Journal of Psychiatry*:

If an individual is described, his or her consent must be obtained and submitted with the manuscript.... The individual should read the

report before submission. Where the individual is not able to give informed consent, it should be obtained from a legal representative or other authorized person. If it is not possible for informed consent to be obtained, the report can be published only if all details that would enable any reader (including the individual or anyone else) to identify the person are omitted [6].

Interestingly, these instructions seem to require that *even the subject of the case report* should not be able to recognize him- or herself in the report. One wonders how far the clinician would need to depart from the salient clinical facts of the case to disguise it even from the patient. Furthermore, radical alteration of the clinical data runs the risk of weakening or confusing the relevant teaching points. Nonetheless, self-recognition on the patient's part—even if not technically a violation of the patient's privacy—presents substantial risks to the therapeutic alliance.

### **Specific Issues for Dr. Zhou**

In the case at hand, there are also ethical and legal issues arising from the patient's status as a minor. As forensic psychiatrist Robert Simon has noted, confidentiality statutes may distinguish between “young minors” and “emancipated minors”; i.e., minors aged 14 or older may be considered “emancipated” when they are not living at home or are self-supporting [7]. In general, the parents or legal guardians are the legal decision makers for young minors. This may not apply in the case of emancipated or “mature” minors, who may be deemed sufficiently mature to consent to treatment—and, by extension, to publication of case material. How Dr. Zhou should proceed in the case of “Teresa” may depend, in part, on the formal or informal understanding Dr. Zhou has with the patient and her parents (see below).

Finally, Dr. Zhou has to consider her motives in publishing Teresa's case history. These bear on the physician's responsibility to put the patient's needs first, under the rubric of beneficence and nonmaleficence. For example, Dr. Zhou might do well to reflect on whether her desire to publish represents a legitimate wish to educate colleagues or a more self-focused need to “please” her attending physician or secure her entrance into the fellowship program. Of course, most ambitious physicians want to advance their careers, as well as win the approval of their supervisors and teachers. These feelings per se should not preclude publication of a case—but they may merit a process of reflection, introspection, and consultation with supervisors or colleagues.

### **What Should Dr. Zhou Do?**

In my view, there is no single “right” answer to this question. Given Teresa's age and the ongoing nature of treatment, I would be inclined to obtain both Teresa's permission and that of her parents. However, my opinion might differ if Dr. Zhou had worked out a clear understanding or therapeutic contract with Teresa and her parents, stipulating otherwise. For example, some mature or emancipated minors might not want to have any communication with parents, a preference the physician

should honor except when there is a question of “danger to self or others,” e.g., in the event the (minor) patient became suicidal. When such an understanding exists, the patient herself would be presumed competent to consent to publication. Clearly, it is important for physicians to work out a therapeutic contract with their patients regarding publication of case material—though I suspect this is rarely done. It is especially important in cases involving the treatment of younger or nonemancipated minors.

### **Conclusion**

Determining the best approach in Teresa’s case is indeed a difficult judgment call, and it behooves the physician intent on publishing case reports to plan ahead for similar contingencies. In situations where possible harm to the patient or to the therapeutic alliance appears to outweigh the “teaching value” of the case report, the physician may be obligated to withhold publication entirely. As this is a complex, highly subjective determination, consultation with a senior colleague or supervisor may help the physician reach a more objective decision.

Alternatively, some physicians may choose to *collaborate* with patients in writing up the case report, as was suggested by psychiatrist Michael A. Schwartz in a personal communication in 2007. Of course, as he pointed out, this collaborative model poses its own set of problems, e.g., what to do when the patient wants to delete material that the physician wishes to include. Other physicians intent on publishing clinical cases might consider an informed-consent process at or near the beginning of treatment. This would apprise the patient of the physician’s usual policies regarding case reports and allow the patient to express concerns or even to “opt out” of the writing project. This sort of consent procedure must convey to the patient that the physician’s care and treatment will in no way be jeopardized if the patient chooses *not* to be the subject of any case reports.

Perhaps, then, we are left with this open-ended assessment by psychiatrist Glen Gabbard:

No approach [to publishing case material] is without its problems. A clinically based decision must be made in each case regarding whether the best strategy is to use thick disguise; to ask the patient’s consent; to limit the clinical illustration to process data without biographical details...or to use composites [8].

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### **Commentary 2**

**by Judy L. Kantrowitz, PhD**

Although Dr. Zhou's mentors disagree about whether it is necessary to ask Teresa's consent, as professionals they would agree that when clinical material is published it must be written in such a way that people reading the account are unable to identify the patient. But how can the author be sure? What kinds of disguise can the writer provide to maintain the relevant facts of the case while concealing the patient's identity? In this instance, the patient is an adolescent, and it is likely that her age is relevant to her difficulties. So changing her age in any dramatic fashion would distort the material; it could only be altered slightly. What about a change in gender? We would have to know more of the details of the case to determine whether such a change would or would not distort the report. Could Dr. Zhou change the particular substance that Teresa uses? Maybe. Again it would depend on details we don't know. So what other ways of disguising are possible? She could alter details of history that are not pertinent to this patient's difficulties, such as her parents' professions, her number of siblings, whether there is a family history of bipolar illness and, if so, which relative suffered from this problem.

The point is that Dr. Zhou must be sure that the disguise she uses really protects her patient's confidentiality—that others reading the article won't recognize her. Dr. Zhou's mentors would agree on this. I hope that neither of her mentors would allow

someone who was new at writing about patients to decide what degree of disguise was adequate. But what level of de-identification would keep the patient herself from recognizing her own story? The patient is a teenager and unlikely to read the psychiatric literature, but she will grow up and might be curious. Also, in this instance, one of her parents is a university staff member, someone who, depending on the field, might read a psychiatric journal. In addition, now that published articles are likely to be available on the Internet, they are available to the public and, specifically, to patients and their families as never before. Any curious patient can simply enter a therapist's name, find out what he or she has written, and most likely view the article.

The author needs, therefore, to ask herself how Teresa would feel if she read this. Can Dr. Zhou write the case in such a way that her patient (or her patient's parents) could read it years later and think, "That sounds like me, but I'm not sure it is. Could she have had another patient with a similar problem?"

In addition to the issues of disguise, clinicians must be careful, respectful, and sensitive in what they write about their patients, and how they do it; describing the patient in a manner that makes her feel like a specimen or otherwise demeaned must be avoided. How would Teresa feel reading about herself? Would she feel misrepresented? Objectified?

### **Does Writing Change the Treatment Dynamic?**

Dr. Zhou thinks that Teresa wouldn't necessarily mind being written about, but she wonders how asking for permission might change the dynamic in the treatment. Her concern about the effect of asking permission is well-founded and indicates her sensitivity as a clinician. Patients often grant this permission. They want to please their therapists, and some understand the importance to the field of disseminating knowledge through publications. Because their granting permission is influenced by the relationship and transference to their doctor, it can never be viewed as fully autonomous consent.

In this case, the patient is not an adult and may not be aware of how she will feel about her case being in print when she is older. Consent should be asked of her parents as well. If, however, they were to read what Dr. Zhou writes, as her mentor suggests, Teresa's confidentiality would no longer be preserved.

How will knowing her doctor is writing about her affect their therapeutic relationship? It is unpredictable, but there will most likely be some effect. If Dr. Zhou's request is granted, she will need to be alert to signs of reaction, e.g., a change in the patient's openness or her mood, negative feelings, or apparent criticisms of other adults that might actually have to do with her feelings about Dr. Zhou. Teresa's feelings about being written about and their effect on the treatment itself need to be explored. Is that workable? It depends on the patient, therapist, their relationship, and their ability to talk openly together about what Teresa thinks and feels.

Teresa might only react later. For example, I asked a patient if I might use a childhood experience of hers to illustrate a point in a paper I was giving. She reflected on the possible ramifications and then gave consent. A year later, she asked me to write a recommendation for her that would require my providing a dynamic diagnostic assessment. I tried to analyze her wish for me to do this, the meaning to her of what she imagined I would write, and so on. Ultimately it was clear to her that this was not something I would do, since I believed it would interfere with her treatment. “So,” she said, “it’s fine for you to write about me when it’s in your interest, but not when I believe it is in my interest.” While we were able to work out this therapeutic tangle, her reactions alerted me to be aware that consent may well be much more complex than it seems at first.

Informed consent is never fully informed because the meaning of having given it may not be fully conscious and it may change over time. A patient may think he or she really likes the idea of being written about; it makes him or her feel special and specially connected with the therapist who asks this permission, but the sense of specialness may come to interfere with other aspects of the patient-physician relationship.

### **Patient-Vetted Literature?**

Stepping back from the individual patient-physician dyad, there is the broader danger that, should informed consent become the accepted standard for publication, all subsequent literature would be patient-vetted. A literature that depended on patient approval would be skewed, inasmuch as clinicians would avoid addressing issues, such as negative countertransference reactions, that they wouldn’t want patients to be privy to. Exclusion of such topics from the literature could lead therapists to believe these areas did not exist for others or, at the least, should not be acknowledged publicly.

Given all these potential difficulties, why should Dr. Zhou write about Teresa? If her attending physician is correct that she has done therapeutic work that can help distinguish bipolar disorder from substance-induced mood disorder, she has a contribution to make to the literature. A field that lacks an up-to-date literature will stagnate. We need the enrichment that comes from peer-reviewed articles. Published papers are also an important and necessary way of preserving a history of any given field.

Therapist-authors wear two hats. First they are clinicians who have promised to do no harm, but they are also professionals who are committed to keeping intellectual discourse and ideas vibrant and relevant in their field. These two roles may sometimes conflict with each other.

In the course of working on my book, *Writing About Patients: Responsibilities, Risks, and Ramifications* (2006), I interviewed 141 clinicians about their attitudes and practices when writing about patients and 37 patients about the effect of reading about themselves. From these interviews, I concluded that there is no single or



simple solution to the problem. Applying strict guidelines to all situations does not make clinical sense. There are potential clinical consequences both when therapists ask their patients' consent and have them read what they have written and when patients discover and read publications about them without having been informed. The ethical principle that guides the decision is "do no harm." But what is harm is not always predictable.

If Dr. Zhou wishes to write about Teresa, who is not old enough to fully understand the implications of granting consent, involving her parents in the decision making will necessarily compromise her confidentiality and may jeopardize Teresa's trust and the therapeutic relationship. If Dr. Zhou does not ask permission and uses only disguise, how likely is it that Teresa will be recognizable to herself or her parents if they read the paper? If Teresa does recognize herself, can she talk openly and honestly with Dr. Zhou about her reactions? Has Dr. Zhou considered how she would respond? How it might affect the treatment? If she decides to ask permission, is she ready to accept a refusal? If Teresa or her family wish her to alter or omit parts of what she has written, would she be willing to do so or not pursue publication?

There are no clear answers, only self-scrutiny, seeking consultation, and using one's judgment.

### **Conclusion**

Since Teresa is a minor and parental consent would be needed, confidentiality would be broken. Such a breach of confidentiality could jeopardize her treatment. Therefore, unless Dr. Zhou can find a way to adequately disguise her patient so she feels reasonably sure that neither Teresa nor her parents will recognize themselves, I believe she should not publish this case.

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# Virtual Mentor

American Medical Association Journal of Ethics  
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## CLINICAL CASE

### Ethics, Memoir, and Medicine

Commentary by Jack Coulehan, MD, MPH

Dr. Cushman has spent 10 years as an internist in a county hospital in urban Los Angeles. When he began his residency, he realized how many of the city's underserved, poor minority and immigrant populations relied on the hospital for care. Moved by the dire medical needs of his patients and their communities, he stayed on as a chief resident and later became an attending physician.

He has always seen his work as meaningful and rewarding, but recently he has begun to feel strained by the challenges of indigent care. Many of his patients suffer from diabetes, obesity, substance abuse, or HIV—chronic conditions that he can manage, but rarely cure. Many are homeless, subject to violence, and lack the means to maintain their health outside of the hospital, trapping them in a cycle of deterioration and readmission. He sometimes feels that, despite the excellent care he and his team provide, there is little he can do to oppose the pervasive effects of socioeconomic circumstances on his patients' health. His wife suggested that he take a writing class to help him cope with the stress, and he has been writing reflective pieces about his experiences at the hospital and with particular patients.

Inspired by the memoirs of other physicians and with the encouragement of his writing teacher, Dr. Cushman finally collects his essays and sends them to a publisher. Not only has the experience of writing down and sharing his feelings has been cathartic, but he also feels that a memoir for a lay audience will help bring awareness of the plight of his underserved patients. His book, *Picking up the Pieces: An Urban Doctor's Story* is published, and a brief review appears in a major medical journal.

To Dr. Cushman's surprise, the review gets a flurry of responses from physician readers. Some are sympathetic to the challenges he highlights in his book, but others are less complimentary. Several reviewers express concern about the way he has portrayed other physicians, particularly his former attending physician's callous attitude toward certain groups of patients. Other commentators raise the issue of exploitation. Whatever Dr. Cushman's intentions, and no matter how well his individual patients are disguised, one commentator argues, he is benefiting, morally and financially, from "their" stories. How should Dr. Cushman see what he has done?

## Commentary

Dr. Cushman's memoir invites us to consider the moral texture of creative nonfiction in medicine. *Picking up the Pieces* has elicited a variety of responses, some praising the work's truthfulness and others raising ethical questions about patient exploitation. We're not asked which of these views is correct, but rather, "how should Dr. Cushman see what he has done?" I take this to mean Dr. Cushman's moral assessment of his work, which requires that we consider his values and motivation. However, the word "should" suggests that we also need to step back and assess the case from the perspective of moral rules and principles in medical practice.

Before tackling the question, however, I want to comment briefly on the phenomenon of medical memoir. *The Horse and Buggy Doctor*, Arthur E. Hertzler's memoir of life as a general practitioner in Kansas, became a national best seller in 1938 [1]. Dr. Hertzler's book promoted the mythic image of the country doctor as a dedicated, hardworking, and plainspoken font of practical wisdom, full of compassion but also, when necessary, a purveyor of tough love. Hertzler told his readers a lot about himself in *The Horse and Buggy Doctor*, but virtually nothing about his individual patients. The book was unquestionably his story. In the decades since then, medical memoir has developed into a popular subgenre, but its terms of engagement, so to speak, have radically changed. Nowadays, stories about specific patients (and also colleagues) are frequently an integral part of medical memoirs. And why not, one might ask. The foibles and suffering of "real" characters are more interesting than generalizations about one's life as a doctor. Consider, for example, a publicity blurb for a recently published memoir emphasizing the "actual" patients, families, physicians, and nurses described in the pages of its "firsthand" account.

Dr. Hertzler would not have approved. He believed in a high standard of confidentiality, based on Hippocratic tradition, medical virtue, and the need for trust in the physician-patient relationship [1]. While he certainly had a paternalistic attitude ("Doctor always knows best"), his paternalism didn't include spilling the beans about his patients. Our contemporary perspective on this issue is different. In one sense we have an even stronger commitment to privacy and confidentiality because we ground them in the ethical principle of autonomy or self-determination. We speak of human rights, informed consent, and shared decision making, rather than the fuzzier concepts of paternalism and medical virtue. At the same time, however, we live in a culture of information overload where privacy is honored more in theory than in practice. Prurient disclosure has become the norm in autobiography and memoir. And, though protected by law, patient confidentiality is often violated.

In this context we've developed two main approaches to dealing with patient stories in medical memoir. One is informed consent; the other is de-identification [2, 3]. Each of these, however, creates new problems. For example, de-identification, i.e., changing the narrative to make the patient unrecognizable, decreases the factual accuracy of the account, raising the question, "Where does nonfiction end and fiction

begin?” Alternatively, what about the patient who refuses consent? Must we never publish stories about angry, withdrawn, or paranoid patients who, like Melville’s Bartleby the scrivener, repeatedly tell us, “I prefer not to” when asked for permission?

Having set the stage, I want to address the question of how Dr. Cushman should “see” the moral texture of *Picking up the Pieces*. I can identify at least three elements in his overall motivation for writing. First, his original intention was largely therapeutic. He began writing as a form of reflective practice. “Strained by the challenges of indigent care” and realizing “there is little he can do to oppose the effects” of his patients’ life circumstances, he turned to creative writing as a method of coping with the stress. He hoped to give voice to his feelings and, in doing so, understand them better and manage them more effectively. From a moral perspective, this is a laudable goal. It could help him live a more balanced life and become a better healer.

A second motivation is evident in his pursuing the craft of creative writing with formal classes and eventually submitting his book for publication. “Inspired by the memoirs of other physicians,” he decided to use the medium of creative nonfiction to communicate his message to others. His goal here was to create a well-crafted narrative. However, insofar as this involves sharing information about patients, his role as a creative writer may seriously conflict with his duties as a physician, thus raising the moral questions his critics noted.

A third motivation arises from Dr. Cushman’s inability to change the social and economic factors that impair his patients’ health. He believes that “a memoir for a lay audience will help bring awareness of the plight of his underserved patients.” If people become aware of the problem in a way that touches their hearts or engages their sense of justice, perhaps something can be done. Thus, Dr. Cushman’s third motivation is synergistic with the goal of his medical practice: to benefit his patients.

In speculating about how Dr. Cushman should see his memoir, I’ve identified two morally laudable features. His reflective writing may have helped him cope with the stresses of practice and enhanced his emotional resilience, and the published memoir may ultimately generate greater public awareness of his patients’ plight. However, these benefits come with potential risks.

Let me envision two scenarios for Dr. Cushman as he prepared to publish *Picking up the Pieces*. In the first case, he has taken the paternalistic attitude that his patients are, after all, poorly educated and lack the sophistication necessary to understand his project. He also felt that authorial license permitted him to alter patient stories at will and to invent situations and conversations in the service of a “larger truth.” Consequently, he neither informed his patients about his use of their narratives, nor obtained their consent—but neither did he alert his readers to his practice of altering or inventing patient narratives. Given this scenario, I would have to conclude that, despite his good intentions, Dr. Cushman should see his book as ethically flawed.

Let me make another point about de-identification in creative nonfiction. By definition, “nonfiction” requires factual accuracy. The “creative” element is supposed to be confined to literary style and technique. Nonetheless, authors of memoirs often reconstruct characters, events, and conversations from memory, perhaps with little or no documentary support. Moreover, the memoirist packages his or her experience to present a coherent narrative. In this process, the author might delete, merge, or alter material in the pursuit of “truth.” Although perhaps appropriate, this can constitute a breach of contract with readers, unless the author lets them in on the secret. Readers of books like the one whose publicity blurb I mentioned above rightfully expect an unvarnished firsthand account of actual patients, just as advertised. The remedy for Dr. Cushman would be to explain the criteria and process he used in de-identifying or re-imagining the narratives included in his book.

I purposely didn’t mention Dr. Cushman’s portrayal of other physicians in this scenario. Some reviewers took him to task for these characterizations, especially of “his former attending physician’s callous attitude toward certain groups of patients.” This could be a violation of professional ethics insofar as the Hippocratic tradition requires us to honor our teachers. While keeping professional ethics in mind, I think judgments about propriety must be individualized, based on the importance of the characterization to the overall narrative. I imagine some readers would consider a given characterization to be truthful and fair, while others would call the same description truthful, but rude and inappropriate, and still others would look upon it as exaggerated, mistaken, or libelous. If, in fact, Dr. Cushman’s anger over his attending physician’s attitudes contributed significantly to his decision to dedicate his life to caring for the poor, the portrayal represents a crucial feature of his life experience and should be included in the memoir, even though it reflects negatively on his teacher.

In an alternate—I would like to believe, true—scenario, Dr. Cushman has crafted his stories in such a way that they remained truthful to his experience as an inner-city physician, and though he altered many identifying features, he was careful to preserve crucial details, recognizing the importance of thick description in narrative. He showed relevant parts of the manuscript to patients who appear as characters in the book and requested their permission to publish. If a patient had died or lacked capacity, he obtained consent from their next of kin. Finally, he included an author’s note that explained how he handled patient information and noted the type of factual changes he introduced.

This second version of Dr. Cushman should look upon his work with moral satisfaction. If critics charge him with exploiting patients, he can feel confident that he has done everything he could to avoid even the appearance of exploitation. If he wins recognition and awards on the basis of his book, he can accept them gratefully and with a good conscience.

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## Related in VM

[The House of God—Is it Pertinent 30 Years Later?](#) July 2011

[The Poetry of John Stone, MD](#), July 2011

[Anonymous Physician Blogging](#), July 2011

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# Virtual Mentor

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## CLINICAL CASE

### Anonymous Physician Blogging

Commentary by Bryan S. Vartabedian, MD, Emily Amos, and Jay Baruch, MD

After a long day at work, Dr. Baker sits down to check her email and finds a forward from an old medical school friend. “I thought you’d enjoy this,” her friend has written. The link takes her to a blog called “theGrouchyMD: musings of an overworked Texas OB/GYN resident.” The first post tells the story of “Jane,” a 53-year-old woman trying to get pregnant. The blogger expresses the opinion that “Jane may be well intentioned, but I can’t help thinking that what she’s doing is selfish and irresponsible” and posts some links to news articles on uses and misuses of reproductive technology. A lively debate follows among blog readers, who identify themselves as members of the public, medical students, and other physicians. Earlier posts are on topics ranging from health care reform to “war stories” (“Caught a twin vaginal delivery today,” reads one post, “textbook! Now that’s real obstetrics!”). Some posts are centered on readers’ questions, like one explaining the differences between some types of oral contraceptive pills.

As she scrolls down, Dr. Baker becomes increasingly concerned; the patients begin to sound familiar, as do “Dr. B” and “Dr. H,” theGrouchyMD’s colleagues. The blogger apparently not only practices in the same hospital as Dr. Baker does, but appears to be in the same program. The next day, Dr. Baker confronts Dr. O’Connell, her fellow third-year resident. “You’re theGrouchyMD, right?” she starts. “I’m concerned about what you’re doing. I know you changed the names, but what if someone recognizes herself? Sometimes you say some pretty edgy things about the hospital and the residency. What if someone in admin gets hold of it? I’ve also heard of blogs getting used in malpractice suits. Did you think about that when you talked about the placental abruption Dr. H missed last month? And what about you giving people advice on there—I don’t think that’s very smart either.”

Dr. O’Connell sighs. “Look, sometimes I just need to vent,” she says. “I don’t think I’m hurting anybody. I change all the names and identifying information, I always ask if I’m going to put up a picture, and I never give people advice about their specific medical conditions. I think it’s really useful for people to get sensible general advice on their health from a real doctor, not just whatever junk is out there on the web.”

Dr. Baker replies, “I don’t really have a problem with your blog, I just don’t think you should talk about patients or the hospital on there.”



## **Commentary 1**

**by Bryan S. Vartabedian, MD**

As a physician active in the health blogosphere since 2006 and Twitter since 2008, I've had the opportunity to watch the adoption of social media by the medical community. Over the course of just a decade, many of us have evolved from audience to publisher. With the ability to publish has come the responsibility to conduct ourselves professionally both as physicians and citizen journalists. I've personally had to confront many of the professional issues facing doctors in this new medium. The vignette presented showcases nicely some of the challenges facing physicians in the social-media space.

### **Social Media Challenges**

*The discussion of patient-specific information in the public arena.* With the power to share stories comes the power to share stories about patients. This creates a problem for the physician engaged in social-media publishing. Patients may not want their care discussed and the law prohibits the disclosure of protected health information. Some physicians who share patient stories de-identify information through the alteration of critical details. But it's important to realize that a physician's obligation to her patient is not defined only by federal law. Consider the physician who properly de-identifies patient information and discusses the case in a public forum. If that physician's patient were to see the blog post or Tweet, it could interfere with the relationship. Our commitment to patients goes beyond HIPAA. The safest strategy for physicians tweeting, posting, or writing online is to avoid any discussion of patient-specific information.

*The danger of anonymity.* One strategy employed by some physicians on social networks is the use of an anonymous profile. "If no one knows who I am, I can't get in trouble," the reasoning goes. The problem is this: there is no such thing as anonymity. People writing under pseudonyms can be easily identified. Anonymity also confers a false sense of security, tempting us to say things that we otherwise might not. The fact that my name and picture sit to the right of every blog post makes me think long and hard about how my ideas will be perceived. I understand that everything I write will be seen by my department chair, wife, mother-in-law and patients. That's a powerful check on bad behavior.

*Immediacy.* When I speak to physicians I always like to make the point that the challenges we face today with social media aren't much different than those faced over the past few generations. Blogs and Twitter for doctors are not fundamentally dissimilar to letters to the editor, articles, or other traditional forms of communication. I think this comparison drives home the point that it isn't the written word that's changed, just the way that it's delivered. *Self-publishing* doesn't have a check on it in the form of an editor.

The most obvious difference is the *immediacy* of communication. Dialogue can take place in real time. Both Twitter and Facebook allow us to share text, video, and pictures of events almost as they happen and to respond to others' posts as fast as we can type. With this immediacy comes the risk of publishing before thorough consideration of the consequences. Impulsive, emotional communication can create problems. And a hasty thought or word can spread very quickly once published.

*Minding your digital footprint.* Another difference between old and new media is that today our thoughts and ideas are easily and permanently retrievable. That edgy letter to the editor that was published 20 years ago now lives only on microfilm. Tweets, blog posts, and Facebook entries become an immediately retrievable part of what we refer to as our "digital footprint"—the searchable body of online behavior that increasingly defines us. While some physicians think about their digital footprint with a certain level of fear, it's important to recognize that what we create and say also has the potential to positively shape the way the world sees us and our ideas.

*New avenues of patient contact.* The increased visibility of physicians in social media creates the appearance of increased availability. Consequently, patients will occasionally reach out to get their immediate health issues addressed, and, while they may be offering implied consent by initiating the dialogue, Twitter and Facebook are poor formats for one-to-one health-related discussion. Beyond the fact that everyone's listening, it is effectively impossible to integrate a Twitter exchange into a patient's medical record. I have also found that patients often don't fully understand privacy settings on the applications that they use.

When approached by patients on any kind of social media I immediately take the conversation offline and do my best to resolve the problem. I try to keep in mind that applications like Facebook are the primary form of communication for some patients, but I usually try to educate them on the potential pitfalls of public disclosure of personal health information. In my experience, patients are always understanding of the limitations of social technology. Finally, I document my encounter in a phone note, making it very clear that it was the patient who initiated the contact.

*Our obligation to participate.* I might finish with the suggestion that as physicians we have an ethical obligation to be involved with dialogue and the creation of health-related content online. Sound reasoning, good clinical information, and evidence-based thinking need to be part of the information stream. And doctors could change the way the world thinks if they would only get together to help create the information that patients see. Consider, for example, the issue of vaccines and autism. If you search for these subjects on Google, you will find the first two pages of search results contain antivaccine propaganda created by a loud, socially savvy minority. The American Academy of Pediatrics has 60,000 members. If every AAP member wrote a myth-dispelling blog post just once a year, Google would be ruled by reason. The medical community has the capacity and power to put good information where our patients seek it—we just need to make it a priority.

As health professionals we have to start looking at this from the perspective of opportunity, not risk. Collectively, we have the capacity to harness the most powerful communication medium since the printing press. We can influence ideas about health. We can change the way our profession is viewed. This is where the patients are, and it's where we should be as physicians.

Concerning Dr. Baker and her handling of “theGrouchyMD,” the direct approach to her fellow resident is the best immediate course of action. As Dr. O’Connell doesn’t appear to see any problem with what’s she’s doing, the question then centers on Dr. Baker’s obligation to go further. And how we define “going further” is unclear; the boundaries of physician conduct in the online space have not been clearly defined. It should be understood, however, that if these stories were to be somehow connected with the patients they describe, those patients could be harmed and the career consequences for Dr. Grouchy could be severe. Anything that helps Dr. Grouchy understand the risks should be seen as an effort to help her maintain a healthy professional future.

Bryan S. Vartabedian, MD, is a pediatric gastroenterologist at Texas Children’s Hospital/Baylor College of Medicine in Houston. He blogs at 33charts.com.

## **Commentary 2**

**by Emily Amos and Jay Baruch, MD**

In this case about a physician blogger, tension arises between online communication and professionalism. While there are parts of the blog that most doctors can relate to—the “war stories,” feeling overworked, a desire to provide sensible medical information—there are also parts that stand out as potentially problematic, like Dr. O’Connell’s “need to vent” or the fact that her identity can be teased out from context alone.

For this case commentary, we will provide a working definition of medical professionalism and address how this case bumps up against the definition. We will discuss differences between conventional print media and blogging, and propose a set of guidelines for physician bloggers to encourage responsible Internet use.

### **Professionalism**

Medicine has always had to adapt to new technology, and the Internet is no different [1]. It represents a new forum for patient-doctor interaction and a new arena in which to test our notions of what it means to be a professional and a physician.

Epstein and Hundert define professional competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” [2]. Herbert Swick suggests that medical professionalism is a set of behaviors, including demonstration of humanistic values, commitment to accountability and reflection, adherence to high ethical and moral standards, and

subordination of self-interest [3]. Using these definitions, we can pinpoint some of the controversial features of Dr. O'Connell's blog, and why Dr. Baker might be concerned about her colleague's online persona, theGrouchyMD.

### **Why Blog?**

Several physician authors have made careers writing narrative fiction and nonfiction for a lay audience through standard editorial and peer review processes. The time-consuming work of revisions encourages thoughtfulness and reflection. The scrutiny and rigor of the editorial process imparts a sense of legitimacy to the book in the eyes of the reader.

Recently, blogging has emerged as a dynamic, powerful tool for online communication and community building, and many physicians have taken up blogging as a way to tell their stories [4]. Unlike academic journals and popular media, the strengths of blogging lie in its accessibility. A democratizing force, blogging allows anyone with an Internet connection to have a say at the click of a button, without editorial barriers. Blogging allows physicians to express thoughts and emotions that might be less prevalent in traditional medical literature. Doubts, fears, frustrations, and disappointment are sentiments that live in the shadows in a profession that values decisiveness, altruism, and boundless compassion.

Blogging as a medium of expression does have a downside, of course. Ease of publication, a fundamental strength of blogging, can also be its Achilles' heel. Passionate, raw emotion that might feel so necessary to articulate at the moment can lead to regret, or worse [5]. Blogging about medicine and health care as a physician requires restraint and self-editing, not unlike the self-monitoring expected of physicians with respect to ethical conduct [6]. In addition, the lack of a structured, recognizable editing body can undermine the perceived quality or reliability of content published in an informal setting like a blog.

In her writing, Dr. O'Connell is utilizing a divisive feature of blogging: writing anonymously. Through more traditional publishing routes, physician writers take responsibility for their work. Blogging, by contrast, allows authors to determine how much of their true identity they wish to reveal. Medical professionalism requires a degree of accountability from physicians, and, while the protection of anonymous blogging permits frankness and candor, it also implies that the author does not want his or her real identity entangled with the stories being shared online [7]. Dr. O'Connell is using her alter ego, theGrouchyMD, to say "pretty edgy things about the hospital and the residency," and it is unclear whether she would make similar statements were she signing her real name.

### **Responsible Writing and Venting**

Physicians are legally and morally responsible for maintaining patient privacy [8]. Physician writers must balance their responsibility and obligations to patients with their duty to readers. When Dr. Baker confronts Dr. O'Connell, the latter defends

herself by saying “I just need to vent.” What is this need, and is it so important that it subordinates the patient’s interests?

Dr. O’Connell defends her writing on the grounds that changing names and identifying information relieves her of wrongdoing. Can an individual patient be de-identified completely? The context of her storytelling provides enough evidence, narrative fingerprints, that those familiar with the events could extrapolate the real identities of the people involved. It is evident from Dr. Baker’s quick discovery of the GrouchyMD’s identity that Dr. O’Connell’s stories pose a potential threat to her patients’ privacy.

Another argument holds that what matters is not whether a patient may recognize herself, but rather that the physician took information obtained in a confidential relationship and used it for personal ends. De-identification doesn’t change the moral breach; it only reduces the physician’s risk of being caught.

The stakes are high for physician writers, who represent not only themselves but also their practice and profession. A physician’s blog is more than a personal journal in the public domain, because readers are also patients [1]. When a physician blogs about a patient encounter, that narrative weaves itself into the public perception of doctors as a whole and can directly impact patient care. Physician writers must be cognizant of their influence and mindful of the potential for harm as a result of their actions.

A negative portrayal of the patient-doctor relationship may cause readers who identify with the patients in Dr. O’Connell’s stories to question their relationships with their own doctors. When Dr. O’Connell criticizes a 53-year-old patient for seeking fertility treatments as “selfish and irresponsible,” she creates a rift between herself and older women pursuing pregnancy and possibly between those women and their doctors—they may worry that their physicians judge them in the same way. Dr. O’Connell also misses an opportunity for self-reflection when Dr. Baker approaches her. She fails to see that her criticisms of older women seeking fertility treatments—selfishness and irresponsibility—could be leveled against her and her blogging.

The accessibility of blogs puts physician writers in a position to have widespread positive impact. Bloggers who represent the best of the medical profession reflect well on everyone in a white coat. Online forums allow physicians to engage a wide audience, where they can dispel misleading or false medical information, participate in discussion of current issues in health care, and shed light on certain aspects of medicine from a physician’s perspective.

Blogs can also be a humanizing element for physicians, a way to connect with people outside the confines of the hospital. In a survey of physician bloggers, the most commonly reported reasons for blogging included sharing knowledge or skills, influencing the thinking of others, and creative expression [9]. Dr. O’Connell identifies these as motivations for her own blogging, saying, “It’s really useful for

people to get sensible general advice,” and sees her physician-authored blog as a way to counteract “whatever junk is out there on the web.” Here, Dr. O’Connell is evincing professional competency, using her technical skills and knowledge for the benefit of her readers. By providing only general medical advice, she is reaching out to those in search of medical information, without venturing into the ethical gray area of online diagnoses [10].

As the Grouchy MD, Dr. O’Connell illustrates both the power and the pitfalls of physician blogging. She is sharing the truth about her experience as a doctor, but treading roughly on patient privacy. She is providing reliable medical information to a large audience, but may be alienating some patients with her cutting commentary. If we were in Dr. Baker’s shoes, what could we offer Dr. O’Connell as a touchstone for appropriate Internet use?

### **How to Responsibly Use the Internet**

Blogging has enormous potential to enrich and strengthen patient-doctor communication if used judiciously [11]. We propose the following guidelines for physician bloggers:

- First and foremost, always employ the Golden Rule of the Internet: if you wouldn’t say it in person, don’t say it online.
- Question intent: if publishing a story will benefit only you, the author, consider keeping it to yourself. A fine line separates thought-provoking and inflammatory commentary, and a narrative that is personal is not necessarily insightful.
- Keep it clean: as a physician in the public eye, you represent not only yourself but also your profession and any affiliated institutions.
- Care for your patients on the page: you are responsible for their well-being even when they are not physically in your presence.

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# Virtual Mentor

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## CONLEY ESSAY CONTEST

### 2010 Winning Essay

#### Social (Networking) Justice

Russell J. Coletti

Emily, a medical school candidate, had high grades and MCAT scores and extensive volunteer experience. The committee members who interviewed her reported that Emily had spoken movingly about her desire to become a primary care physician in a rural setting.

The committee's student member, Jason, looked up Emily on Facebook to see whether they had any friends in common. There he found a link to a blog post that attributed rising rates of contagious disease and unemployment to illegal immigrants. Emily had added: "I couldn't agree more. People whose mothers just happened to sneak over the border at the right time are called 'citizens' when they're just driving down wages, straining our infrastructure, and taking jobs that rightly belong to honest, hardworking taxpayers. Why should we take care of them?"

Emily's Facebook post revealed a side of her that Jason knew the admissions committee hadn't seen, and he wondered what he should do with this information.

### Response

Just when access to information at a moment's notice seems like old news, a growing trend in the virtual world is the ability to share personal experiences and ideas with one's friends and family anywhere. Social networking sites like Facebook and Twitter have allowed insight into an individual's life like never before, but in what situations is such insight appropriate? In the case of medical school hopeful Emily, online social networking activities should not be considered during the selection process for her admittance.

In order to narrow the applicant pool, medical schools have adopted a three-stage process: screening, interviewing, and selection [1]. Because there are a limited number of positions in the entering class, it can be said that admission represents a limited good to be disbursed at the admission committee's will. Given this arrangement, one can see that justice becomes an important part of the selection process. In his book *Beginning Bioethics*, Aaron Ridley defines justice as "giving people what is fair, due, or owed to them" [2], in other words giving people what they deserve. Applying this idea to the admissions process, if the committee determines that an applicant deserves admission, then the committee ought to grant it. The information the committee uses to determine whether the applicant's academic achievements and character are deserving of admission is that which the



applicant submits in the first two stages of the process: screening and interviewing. The end of the interview stage marks the point in the process after which the applicant cannot defend, expand upon, or put into context any information that the committee considers. Equally important is the fact that the applicant has only *knowingly* submitted information up to that point and has thus been in control of its content.

This is not unlike a trial proceeding, in which a jury (analogous to the admission committee) decides on a defendant's deservingness of acquittal (or conviction) based upon information presented during the case. In this arena where, ideally, justice is preserved, the jury is only to consider the information presented formally in court, where the defendant has the opportunity to counter or defend the information presented. Indeed there have been cases in which jurors have used social networking sites, among other Internet resources, to convey or discover information not deemed admissible by the judge, which resulted in mistrials. For instance, in a Florida case where the defendant was accused of selling prescription drugs illegally over the Internet, 8 weeks of proceedings unraveled into a mistrial when several of the jurors conducted online research about the case [3]. Clearly, consulting resources beyond the confines of the proper pathways has been deemed unfair in the legal system, as the information no longer can be properly scrutinized, particularly by the party to whom the information pertains.

Proper, fair pathways also exist in the selection process for medical school. According to the Liaison Committee on Medical Education, which sets accreditation standards for all U.S. medical schools, an institution "must develop criteria, policies, and procedures for selection...that are readily available to... applicants" [4]. Furthermore, the Association of American Medical Colleges dictates that an institution develop "clear, consistent criteria and processes" [1] for selection. Thus, a just process guarantees the applicants both transparency and consistency in the admission guidelines. Indeed there are now actually two criteria for justice within the selection process: (i) that those to whom admission is *due* ultimately receive it, and (ii) that all applicants receive what they are *owed* from the onset (transparency and consistency).

Since it appears that Jason took it upon himself to consult Facebook for his own reasons (common friends, likes, and dislikes), and he is left "wondering what to do with the information," it is unlikely that this is an official committee procedure, so Jason's activities would not have been disclosed to the applicants. He thus violates the transparency requirement of the process. Furthermore it appears that Jason was able to glean the extra (not gathered from the first two stages) information only about applicants who used Facebook and had an open account. Jason's method is therefore inconsistent, unlike the screening and interviewing stages, which all applicants undergo. Thus, if the committee were to consider Emily's social networking activities, then the selection process would be neither transparent nor consistent, making it unjust because all applicants would not be receiving what they are owed from the onset. Were the committee to use this type of inconsistent information,

which may be out of context (remember that at this point applicants cannot defend or explain this information), then it could be argued that determining which applicants actually deserve admission becomes obscured, potentially preventing deserving applicants from being admitted while undeserving applicants receive admission. In this way the process would meet neither justice criterion.

Those who support use of social networking media in the selection process may say that the process is already unjust, as it is nearly impossible to know absolutely who does and does not deserve admission. Furthermore, if committees officially made social networking investigation part of their process, it would allow them access to more material with which to make a more informed decision. It can also be argued that, given the limited spots, not every applicant who deserves admission receives it, so the selection process is also unjust in this way. In response, I assert that, while there are inherent limitations on how much information the committee can gather in the first two stages due to finite interview time and class sizes, those limitations are consistent and institutionally enforced. For instance, all applicants are limited to the same number of characters in writing their personal statements, and all interviews last generally the same amount of time. Conversely, social networking sites are virtually limitless, and the amount and content of information is determined only by the user.

If the committee were to disclose its utilization of Facebook, which it would be required to do if it made such sites an official part of the selection process, then an applicant would be free to alter and add information as he or she saw fit, in effect undermining the candid quality of Facebook that would have been attractive to the committee in the first place. In addition, some candidates may not have social networking accounts, making the process inconsistent, unless the committee required such accounts at the onset. Certain information fields would then need to be specified as mandatory, and the social networking account would become just another element in the formal application to be submitted during the screening stage. Although it is unfortunate that not all deserving applicants gain admission, I argue that it is not the committee's job to grant admission to every deserving applicant; rather, they must ensure to the best of their ability that available space is filled only with deserving applicants—that it is as just a selection process as possible.

A more pressing argument may be that future patients' care is at stake if Emily harbors biases that may influence her ability to fulfill a physician's responsibility to all patients. As a result, this argument goes, Jason has an obligation to inform the committee, even at the risk of making the selection process unjust. Here it is important to look more closely at Emily's comments, which, when the "tone of disgust" is removed, essentially state her opinion against noncitizens who have illegally immigrated and are placing an apparent economic strain on American society. She is not necessarily morally opposed to immigrants or immigration in general. While immigrants (documented and undocumented) do not cost a disproportionate amount of money to treat, their treatment is more likely to be classified as uncompensated care [5], which, one could argue, can cause an economic

strain. It's possible that Emily may decide in the future not to provide uncompensated care, meaning that patients who do not have health insurance will not receive her care. This may even include American citizens without insurance, since many fit this profile, although the percentage of uninsured is lower among citizens than non-citizens. In reality this is not unlike what is currently happening in health care; some physicians have decided not to provide services to the uninsured or even to patients who do have a particular level of insurance [6].

Another illustration of the fact that physicians can deny care is the legal protection they have in refusing to participate in abortions if they are religiously or morally opposed to doing so [7]. In fact no physician, simply because he or she is a physician, is *required* by any oath or law to treat all persons; physicians are traditionally held to the principle of nonmaleficence, but not necessarily that of beneficence. After all, Hippocratic writings say "help or at least do no harm" [8], indicating that above all physicians should not harm patients. Whether physicians are morally obligated to help all others is still debated among philosophers and ethicists. Any policies requiring physicians to treat all patients would most likely be contractually enforced by the individual practice or institution by which the physician is employed, and such requirements are not universal.

While arguments can be made that patients should receive care regardless of their circumstances, whether or not such universal mandates should be placed upon physicians as a result is beyond the scope of this discussion. So although the physicians whose ranks Emily desires to join do treat a significant number of documented and undocumented immigrants, they are not universally required to do so. Therefore to deny Emily admission based upon her apparent bias is to impose upon her a requirement as a potential future physician that physicians are not currently subject to. Such imposition would be unfair unless all physicians had the same requirement, and, because it is not the admission committee's place to impose requirements on current doctors, it should not consider her comments as detracting from her future ability to be a physician. Because the potential outcome of Emily's bias would not prevent her from fulfilling the responsibilities of a current physician, Jason has no obligation to inform the committee, especially when doing so would cause the process to become unjust.

Nevertheless, Emily's comments do sound rather crass, most likely because she expressed her opinions in an unprofessional way. Indeed, unprofessional content posted on social networking sites is not uncommon, with 60 percent of medical schools reporting similar activities among their students [9]. However, professionalism has been identified, together with ethics and communication skills, as a competency that graduates of medical education must meet and that academic medical institutions must incorporate into their teaching [4]. While Emily did display unprofessional behavior in her comments, denying her admission would be undermining the recognized ability of medical students and graduates to grow into professional, respectful physicians as well as the medical institution's ability to help its students become sensitive to and aware of cultural differences. Moreover, through

lessons and personal experiences throughout medical training, it is perfectly reasonable to believe that Emily can learn to conduct herself appropriately in the future and even overturn her present bias. Emily's responsibility is merely to be cautious of what she posts online; her medical training should subsequently prepare her to meet the professionalism standards of a physician.

In summary, it would be unjust for the admission committee to consider social networking activities during the selection process because such practices would violate the principles of transparency (the application process does not state that networking activities are considered by the committee) and consistency (not all applicants post on social networks), while potentially denying deserving applicants due admission. Furthermore, use of such information may lead committees to impose upon applicants standards that are not imposed upon practicing physicians or professional values that the medical curriculum has a responsibility to cultivate in future physicians.

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# Virtual Mentor

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## CONLEY ESSAY CONTEST

### 2010 Runner-Up Essay

#### Social Roles and Semi-Public Spaces on the Internet—

#### The Case of Jason and Emily

Christopher Langston

Emily, a medical school candidate, had high grades and MCAT scores and extensive volunteer experience. The committee members who interviewed her reported that Emily had spoken movingly about her desire to become a primary care physician in a rural setting.

The committee's student member, Jason, looked up Emily on Facebook to see whether they had any friends in common. There he found a link to a blog post that attributed rising rates of contagious disease and unemployment to illegal immigrants. Emily had added: "I couldn't agree more. People whose mothers just happened to sneak over the border at the right time are called 'citizens' when they're just driving down wages, straining our infrastructure, and taking jobs that rightly belong to honest, hardworking taxpayers. Why should we take care of them?"

Emily's Facebook post revealed a side of her that Jason knew the admissions committee hadn't seen, and he wondered what he should do with this information.

### Response

While on his medical school's admissions committee, Jason discovers that Emily, an applicant, has written a comment on her Facebook profile that may conflict with both her self-presentation in her interview and her future professional commitments. What should Jason do? I will argue that Jason should report his discovery to the admissions committee, who should consider Emily's Facebook comment as they review her application, though they shouldn't grant it much weight without further investigation—indeed, Jason should investigate further. More generally, I will argue that admissions officers should gather and consider as much information as possible that is materially relevant to the professional conduct of applicants. But they must obtain this information systematically and fairly, including respecting applicants' reasonable expectations of privacy, and they must weigh all information according to its appropriate context. Before arguing for this general policy and applying it to this particular case, we should review two factors that make this case challenging.

First, Jason acquired information about Emily in a questionable manner. Unlike other information about Emily in her application, the information that Jason uncovered on her profile was found by actively probing unconventional sources, apparently without forewarning applicants. Moreover, Jason visited Emily's personal profile on

Facebook, a network that is renowned for divulging its users' personal information without their consent [1-3], which suggests that on the whole users believe their profiles contain *private* information [4]. These aspects of Jason's actions invite comparison to violations of privacy or ill-gotten gains.

But such comparisons aren't clear-cut. Jason didn't violate Emily's expectations of privacy in a plainly illegitimate manner. For example, he didn't rummage through her garbage or call up her former lovers for confidential personal details; he merely used a completely public search engine open to anyone with Internet access. Indeed, Emily could have set her profile's privacy settings to restrict access by outsiders like Jason if she didn't want the general public to see its contents. Moreover, given Facebook's wide, unrestricted availability, postings on Facebook may not even count as private information, but rather public, or semipublic, communication [4]; politicians now use Facebook as a platform to express their views to the public [5-7].

As a result of these features, anyone judging this situation is confronted with conflicting indications about whether Jason is entitled to this information and about the uses to which he can legitimately put it.

Second, the significance of Jason's finding is uncertain. Jason discovered information about Emily that is provocative, but its utility and relevance aren't self-evident. Anyone can appreciate that Emily's remarks are unflattering; no one looks attractive or charming when expressing unpleasant emotions like anger and disgust, regardless of those attitudes' appropriateness. But the mere possession of unflattering attitudes isn't germane to physicians' ability to discharge their professional duties. Certainly, physicians' personalities affect their ability to do so, but personality is a slim wedge of professional conduct—the medical field tolerates a wide variety of personalities. So by drawing the admissions committee's attention to this side of Emily's personality, Jason risks biasing the admissions committee against her personality alone; indeed, a similar risk would surface if Jason uncovered an especially rosy comment of Emily's that might bias them toward her personality.

For Jason to run this risk, this information's implications must give it broader professional, not just personal, significance. In this respect, it seems troubling that Emily endorses what seem to be alarmingly superficial beliefs about immigration's social and economic dynamics [8, 9], especially considering what such beliefs seem to imply about her understanding of her own medical career plans. But ultimately one cannot tell if her endorsement is superficial without understanding the reasoning behind her beliefs, and her Facebook remarks do not present her reasoning.

Similarly, it seems troubling when Emily says, "Why should we take care of [illegal immigrants and their citizen children]?" But it is unclear how troubling this statement is because it is ambiguous. On the one hand, Emily may have intended her comment about "care" to apply only to government entitlement programs, since it follows a political commentary about "taxpayers." Many reasonable physicians disagree about such programs without undermining their professional commitment to

their patients. If this was Emily's intention, her comment may have limited implications for her professional credentials. On the other hand, Emily's comment may reflect more general indifference toward caring for the disadvantaged—indeed, caring for anyone. For a future doctor not only to hold such an attitude but also to express it openly is genuinely troubling, since physicians treat the suffering and thus disadvantaged. Moreover, such indifference suggests Emily's range of concern for her patients may be much narrower than she indicated in her interview, and this raises further questions about her trustworthiness. Empathy and trustworthiness are foundational professional virtues for physicians, and if Emily's comment reveals character deficiencies in these areas, then her comment strongly weighs against her professional credentials. However, since Emily's comment is open to at least these two interpretations, no one should rush to judgment about her intentions, and so the relevance of her comment to her professional credentials is uncertain, even though it is highly tempting to infer the worst.

Given its complexities and uncertainties, this case makes a poor precedent for general policy; taken by itself, it prompts ethical judgments that are too subtle and conflicting to permit anyone to generalize with confidence about what admissions officers like Jason should do. Rather than draw on this case alone, any ethical recommendation should turn on Jason's and Emily's social and institutional roles, including these roles' expectations and responsibilities.

Among their various duties, admissions officers like Jason are charged with accepting a class of medical students who will become the best doctors (with qualifications about complementary skills, intraclass diversity of interests, and so on). To discharge their task, admissions officers must systematically (so as to avoid bias) gather as much data as they can about candidates; they must sift the data for information materially relevant to candidates' future professional conduct; and they must weigh the evidence appropriately, according to its contextual salience, reliability, and predictive value. But simultaneously, in pursuing this goal officers must respect certain constraints, especially constraints of fairness. Thus, they cannot harass, bribe, or otherwise apply undue incentives to applicants to obtain information; they cannot lie to, mislead, or disproportionately discomfit applicants to manipulate or test them; and they cannot violate applicants' reasonable expectations of privacy. Such encroachments on fairness are clearly prohibited; applicants should expect admissions officers to respect this boundary.

Medical school applicants like Emily are expected to present to the admissions committee their strongest qualifications and to describe their preparation for a medical career, including their history of motivation and initiative, their notable achievements, and their commitment to professional standards and values. But they are also constrained in meeting this expectation by important responsibilities. Most notably, they cannot lie, mislead, or omit information about themselves or their conduct, especially when such information is materially relevant to their medical career. In a similar manner, they are expected to live by the self-presentation that they give admissions officers; in effect, their presentation of themselves and of their



commitment to medical practice is not just a retrospective report but also a promise to which admissions officers should be able to expect applicants to adhere, just as patients should be able to expect their doctors to adhere to such commitments.

In presenting these social roles and their associated expectations and responsibilities, I have tried to draw a fine line between (a) generic platitudes like “admissions officers should fulfill their duties” and “applicants should meet expectations” and (b) substantive, but exceedingly detailed lists of obligatory activities like “admissions officers should check applicants’ Facebook profiles” and “applicants should never discuss issue X on Facebook.” Instead, I have tried to choose descriptions that are both “substantive and generic” [10] like “materially relevant,” “undue incentives,” “reasonable expectation of privacy,” and “contextual salience.” These “thick” [11-15] terms have more descriptive, “world-guided” criteria of application than “thin” terms like “responsibility” and “duty,” but nevertheless retain more normative, “action-guiding” criteria of application than purely empirical labels like “checking applicants’ Facebook profiles” and “discussing X on Facebook.” Such “thick” terms are common in the law (“cruel and unusual punishment” being the go-to example) [16] because they combine the substance and specificity of empirical descriptions with the generality and directive guidance of explicit rules.

When these social roles’ thick descriptions are applied to Jason’s and Emily’s scenario, it is clear that Jason should report his discovery to the admissions committee because it constitutes information that is materially relevant to Emily’s commitment to professional values and that was retrieved systematically and fairly, without violating Emily’s reasonable expectations of privacy. Emily posted her comment in a place where any person—including future patients—might come across it, and since it concerns commitments for which she is responsible now and during her medical career, it should be fair game during the application process. Furthermore, if Emily wanted her comments on Facebook to remain private and inaccessible to outsiders like Jason (or patients), then any reasonable person would have advised her to adjust her privacy settings accordingly. Jason’s visiting Emily’s profile without warning her was not especially transparent or considerate, but it was not for that reason unfair or impermissible.

The harder question is what evidential weight the admissions committee should place on Emily’s Facebook remarks. This question is difficult because it’s not clear what Emily’s remarks really mean or why she endorses them, and it’s hard to hold Emily responsible for this lack of clarity and completeness because she posted it on a web site devoted to informal discussion of personal topics, not professional ones. Readers (including patients) cannot reasonably expect the completeness or precision in Facebook posts (hardly more than in a coffee-shop conversation) that they would in a journal article, newspaper op-ed, or even a professional blog, and so they cannot hold the writer to the more stringent standards applicable to those forms of expression. Therefore, the admissions committee cannot legitimately grant much weight to this piece of information in evaluating Emily’s application.

Indeed, context would constrain the weight accorded to the information even if it were favorable to Emily. For example, when I applied to medical school, my peers were sure that admissions officers would conduct Internet searches on them, so they started blogging about their health care activities and posted Facebook pictures of themselves helping impoverished third-world children. Such self-conscious attempts to sway admissions officers do serve a legitimate purpose: they provide applicants with opportunities to exhibit themselves, including their diligence, conscientiousness, and forethought in anticipating admissions officers' inquiries. But, given the potential for spin, such sources should not receive more evidential weight than conventional sources (grades, degrees, publications, recommendations, interviews), which are less susceptible to manipulation. This example exposes a tempting fallacy lurking in Jason's and Emily's scenario, namely that, since Jason discovered this information covertly it represents Emily's "true," genuine character, whereas the rest of her application is more feigned. But this inference is invalid: Facebook profiles and other Internet sources are just as (if not more) prone to manipulation or misinterpretation than conventional sources and require just as much (even more) careful attention to context. The fact that Emily's comment was (at least) unflattering rules out the possibility that she manipulated her Facebook comment for her advantage, but other contextual features, such as its ambiguity and indeterminate significance, recommend equal caution in weighing its importance.

Since admissions officers are charged with gathering as much information as possible that is materially relevant to applicants' professional conduct, Jason is obligated to follow up on Emily's comment with an e-mail or phone call to ask her to clarify her remarks and to explain her reasoning. It would be rashly premature to assume that Emily's comment was insensitive or revealed deception in her self-presentation; it would be inappropriate to grant it significant weight in evaluating her professional credentials; but it would be downright negligent to fail to follow up on it to determine its full significance.

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## Virtual Mentor

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### CONLEY ESSAY CONTEST

#### 2010 Runner-Up Essay

#### Jason's Journal—Thoughts of an Ethically Conflicted Medical Student

Ankoor Shah

Emily, a medical school candidate, had high grades and MCAT scores and extensive volunteer experience. The committee members who interviewed her reported that Emily had spoken movingly about her desire to become a primary care physician in a rural setting.

The committee's student member, Jason, looked up Emily on Facebook to see whether they had any friends in common. There he found a link to a blog post that attributed rising rates of contagious disease and unemployment to illegal immigrants. Emily had added: "I couldn't agree more. People whose mothers just happened to sneak over the border at the right time are called 'citizens' when they're just driving down wages, straining our infrastructure, and taking jobs that rightly belong to honest, hardworking taxpayers. Why should we take care of them?"

Emily's Facebook post revealed a side of her that Jason knew the admissions committee hadn't seen, and he wondered what he should do with this information.

#### Response

*Below are a few of Jason's journal entries starting the day he interviewed Emily.*

#### Oct 19, 2010

I never thought I would regret having a half day off from the wards to be a student interviewer for medical school applicants. But right now, I wish I had never interviewed Emily. I wish I had never looked at her Facebook profile. I wish I were never put into this situation.

When I first met the faculty on the admissions committee today, there was something said that stood out to me. One of the clinicians was on a diatribe about how to put a number on a MCAT score, GPA, and interview performance combination. The other interviewer, Dr. Schwartz, leaned towards me and said, "it's all about what type of feeling you get after talking to the applicants. And if we are all truthful to each other about what we really think, then there will be no problem in making the right decision." Why did he have to use the word "truthful"? He slipped that lexicon dagger right in the middle of the compound sentence.

So do I have a duty to my fellow members of the admission committee, my so-called colleagues of the day, to be honest about what I truly think of Emily? I remember

reading about philosopher Margaret Gilbert's views on the idea of a plural subject, which in this case would be the admissions committee. She explains that each member of the plural subject is obligated to all members of the whole. For a plural subject to succeed, there must be an "interdependence of commitment" [1]. Even the *AMA Code of Medical Ethics* states that "physicians' relationships must be based on mutual respect and trust" [2]. If I follow the same train of thought, I must be truthful to my colleagues.

It's getting late, and I still have to read about my patient, Mr. Suarez, whom I admitted today. He's a 51-year-old with significant alcohol abuse who presented with a history of epigastric pain and weight loss. A history professor from Bolivia, he is actually one of the nicest patients I have yet to meet. During my physical exam, he continued to quiz me on Latin American history, about which I, of course, knew nothing. Generally happy appearing, his eyes gave the only clue to his true fear. That uneasiness must have been amplified toward the other members of the medicine team because he failed to mention his past alcohol problem to everyone else. He told me he didn't mind the team knowing, but he did not believe it was important.

I'm glad I was truthful to my team about his alcohol abuse because it will directly affect his care. Did I just use the word truthful? I guess my subconscious has a better sense of humor than the conscious me does. Nevertheless, I did fulfill my duty to my colleagues and team regarding Mr. Suarez's alcohol history. Likewise, I should respect my responsibility to my fellow committee members and tell them about Emily's Facebook post. Well, I'll sleep on it for a couple of days.

### **Oct 22, 2010**

Mr. Suarez has not gotten better these last few days, but at least he is not worse. The idea is that he has pancreatitis that just needs rest and waiting to heal. Well, that's my idea, or more realistically my hope now. During rounds today, pancreatic cancer was tossed around as casually as orders for lunch. But of course, the team decided that I should tell him we need a CT scan to "further differentiate etiologies of his epigastric pain." I wondered all day if I could just use that quote and sprint out of the room before he asks any questions. Given that I was cut from JV track in high school, I figured I should search for other ideas. In the end, if his autonomous right as a patient is to be respected, then he needs full disclosure in order to make informed decisions regarding his care. I told him we need the scan to see whether he has cancer. The room fell silent, and I just sat there wondering if I had made the right decision.

Looking back on the day, I am more confident in my decision for transparency with Mr. Suarez. On another note, I still haven't told the admissions committee about Emily's Facebook post. They will not discuss her application for another few weeks—so I still have time. Thinking back to Mr. Suarez, does the medical school have a duty to be completely transparent in its admissions procedures to Emily? She knows that she will be judged on her grades, MCAT score, application essays, other activities, and the interview. However, there is nowhere any mention of Facebook to

be one of the judging criteria. Transparency and truthfulness are such basic moral tenets that the best way I can think about them is by referring to Plato's and Aristotle's thoughts on virtue ethics. Basically someone with strong moral character will naturally be completely truthful and open because it emanates from his character. There should be no need for a motivation to be transparent; it is inherent in one's moral fiber [3]. A modern virtue ethicist, James Wallace, believes that truthfulness and transparency are a "condition of communication" [4]. So what type of moral character do I have by not being transparent with Emily about my own judging criteria?

By even looking on Facebook for Emily's post, I have broken a trust between the applicant and the committee. I broke the rules implicitly agreed upon by both sides. There is no way I can tell the committee about her post. I should have never looked at it in the first place.

### **Oct 23, 2010**

Mr. Suarez's lab values are improving, but he continues to look about the same. Now we are just waiting on the results of the CT scan. With nothing really new to report, I figured I would just see how he was doing after rounds today. He quizzed me again on Latin American history, and, again, I amazed him with my utter lack of knowledge. He then turned serious and spoke about the privilege I have as an aspiring physician and how I should not take that responsibility lightly. He said, "You know, as a doctor you are allowed into the most intimate and important moments in a person's life. From an infant being born, personal secrets, true fears, to a loved one's death, your patients will allow you to see them at their most vulnerable. Your words have the power to change someone's life. Cancer or not, right? As a relative stranger, you automatically become a most trusted confidant just by your title." He paused for a moment, as to gather his thoughts or hold back the tears. "So you must honor your profession. We as patients assume you will be caring, gentle, understanding, and above all else, we assume you will genuinely work your hardest to care for the sick no matter what." Hearing this directly from my patient—my friend—spoke volumes to me.

If I have this duty to my medical profession, then am I being responsible by being silent about Emily's Facebook post? As a member of the medical community, I have an obligation not only to my profession's principles but also ultimately to future patients. I am reminded of ethicist Michael Pritchard's thoughts on professional integrity. He states, "Although no one may have the right to steal something from me, professionals in my service provide me special assurance that I can trust them not to do this. They do this, not by explicitly saying so, but by presenting themselves to me as professionals" [5]. So the question is: Is Emily ready to join the medical profession where implicit assumptions about caring are placed on her?

Reading Emily's Facebook post again, I do not really believe that she will "be caring, gentle, understanding and above all else, genuinely work her hardest to care for the sick no matter what." I know I have been going back and forth about telling

the admissions committee about her post. But if I truly want to respect my profession, it is my duty to tell.

### **Oct 25, 2010**

As bad as today was for me, I am sure it was infinitely worse for Mr. Suarez. The preliminary report for his CT scan came back as negative for pancreatic cancer. I was ecstatic, and before even running it by my team, I told Mr. Suarez. He let out a huge sigh as if this enormous weight was lifted from his shoulders. I wish I could have just stayed in that moment. More importantly, I wish I had spoken to my attending or the radiologist before I jumped to a conclusion. But I did not. In short, the final CT scan report came back “inconclusive to rule out cancer.” Then the MRI confirmed the impossible to me, but the inevitable for Mr. Suarez—a mass on the pancreatic head. I can’t even write how the conversation between the team and Mr. Suarez went without shaking. My embarrassment being covered by my sorrow created a blur of the events.

It was my misinterpretation of the validity of the CT report that caused Mr. Suarez to gain false hope. If I had been more thorough in my investigation, the already bad news would have not been worse.

I still have not told the admissions committee about Emily’s post. Today’s events have shaken my confidence in my judgments. Is it possible that I could be misinterpreting Emily’s post as I did the CT results? Misinterpretation is inherent in our medical culture. Earlier this year in the *Journal of the American Medical Association*, I remember reading an article that reviewed the validity of other journal articles. It concluded, “The reporting and interpretation of findings [in a majority of journal articles in 2006] was frequently inconsistent with the results” [6]. If I cannot read a scholarly article from one of my colleagues without scrutiny for validity, then how can I not give the same in-depth examination to Emily? There is a possibility that she is being ironic or that someone else went onto her Facebook account and wrote that. Without actually giving her the opportunity to defend herself, it is unfair to place judgment. I misinterpreted information already once today that resulted in devastating consequences. I do not want to make the same mistake again. I will keep Emily’s post to myself.

### **Nov 2, 2010**

The intense and exciting rollercoaster of my internal medicine clerkship is finally over. Mr. Suarez forgave me for my mistake and I’m actually going to be with him tomorrow during his surgery to remove the mass. Also, the admissions committee will meet in a couple of days to discuss Emily’s application.

Thinking more about it, the medical school application process is inherently unfair. How can we know what type of doctor someone will be? I am sure people are rejected who would have been phenomenal, while current medical students will prove to be less than ideal physicians. Over 40,000 people apply to medical schools each year, and only 18,000 actually matriculate [7]. At my medical school, we only



interview 11 percent of the applicants and accept far fewer [8]. There is a possibility that, by Emily's being accepted, someone deserving will be rejected.

Today, I received an evaluation from my attending. I generally did well, but the last question on the assessment struck me. It asked, "Would you allow this student to care for one of your loved ones?" Though a simple question, it encompasses how physicians should be judged. In the past few weeks I have weighed the pros and cons of telling the admissions committee about her post. But ultimately it boils down to that straightforward question. Would I let Emily care for one of my loved ones? No, I would not. Tomorrow morning I am letting the admissions committee know about Emily's post.

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# Virtual Mentor

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## MEDICAL EDUCATION

### Medical Students Learn to Tell Stories about Their Patients and Themselves

Johanna Shapiro, PhD, Elena Bezzubova, MD, PhD, and Ronald Koons, MD

A small group of third-year medical students and interdisciplinary faculty sit around a table. The students look weary—stethoscopes slung around their necks, white coats slightly rumpled, pockets overflowing with smartphones, pens, scraps of paper, a half-eaten candy bar. They are not sure what to expect, but they are glad to sit down.

“Tell us a story about one of your patients,” an attending physician invites the group.

The students exchange uncertain glances. Finally, one takes the plunge. “Patient is a 32-year-old Latino male who presented with—”

Another faculty member smiles as she holds up a hand. “That sounds like a case presentation. Tell us a *story*.”

So begins an hour-long session in the internal medicine clerkship. One by one, students tell stories about their patients. Faculty and peers listen, eventually question, comment, and probe. The encounter touches on ethical, communication, and relational issues, but its primary goal is to introduce students to the concept of narrative medicine. At its core, the session is designed to help students appreciate the value of attending to the patient’s story and realize that when we tell stories about our patients, we are also telling stories about ourselves.

Students enter their third year longing to work with patients. Inevitably, this means learning something about the events and experiences that make their patients unique human beings. But students discover that their physician role models are often more focused on evidence-based medicine than patient-centered care. There does not seem to be enough time to listen to patients’ stories, or they are deemed “not relevant” to clinical care [1, 2]. As a result, these third-year students lose the opportunity to acquire compassion and empathy for their patients. If we, as their teachers, are not attentive to the narrative aspects of medicine, students’ capacity to relate to their patients’ stories might be lost.

The narrative medicine movement developed with the aim of returning attention and emphasis to patients’ stories [3-5]. The pioneering work of Rita Charon highlighted specifically literary aspects of patients’ narrative, such as frame (why the story is being told and for what purpose), tone (language, metaphor), time (both the chronological trajectory and the significance of time in the story), plot (what happens), and desire (what motivates the narrator to keep telling and the audience to

keep listening to the story) [6]. Charon argues that narrative competence, including how to interpret, respond to, and be moved by patients' stories, is an essential component of doctoring [7]. The inclusion of narrative medicine approaches in medical education is intended to stimulate critical thinking, develop moral imagination, and foster the desire to act beneficently to promote patient welfare.

Drawing upon this framework, the patient stories session introduces a narrative approach by addressing five specific objectives. First, it helps students distinguish between a "story" and a case presentation [8]. This is a valuable distinction. Case presentations organize facts; stories, with their coherent narrative arc, provide meaning [9, 10]. It is only the patient's story that can tell us what the illness *means* to the patient, how illness has interrupted and perhaps permanently altered the patient's life. By focusing on the patient's view of his illness, the storyteller mentioned above began to reflect on what it might be like to be his patient—a young man with rectal bleeding untreated for a year because of lack of insurance.

Second, the session helps each student hone important listening skills such as attentiveness, curiosity, imagination, and emotional awareness [11], both by listening to the stories others tell and by listening to *oneself telling the story*. In this particular session, participants attended carefully to the metaphors and language the presenting student chose, as well as his body language, tone of voice, gestures, and silences. We were engaged with the plot twists in the story (the appearance of the patient's lover), as well as its climax (the student's disapproval of the patient's attraction to same-sex partners). This kind of listening is different from the standard history taking modeled on the wards, in which the student focuses on extracting from the patient certain kinds of information judged to be pertinent to the diagnosis. When the student truly listens to a story, he or she seeks to enter that story as an empathic participant. Arthur Frank, a medical sociologist, calls this listening *with*, not merely listening *to* the story, because of the additional emotional resonance [12].

Third, by becoming involved in the patient's care, medical students discover that they have also become involved in the patient's story [13]. Inevitably, when they begin to tell the patient's story, they leave their "handprints" all over it [14]. They have become characters in that patient's story, and the patient has become a character in theirs. In the narrative described above, the student described a patient with whom he strongly identified: both were young and male, and they had certain cultural experiences in common. Yet he was a relatively privileged medical student, while the patient had avoided visiting a physician because he had no way to pay for care. This divergence troubled and confused the storyteller. Through the group discussion, he became aware that, to fully understand his patient's story, he had to understand and become comfortable both with how it resembled and how it differed from his own.

Fourth, through storytelling, students move from a facts-based to an empathy-based understanding of the patient. When this occurs, an emotional connection is formed. Students begin to identify and explore both the patient's and their own emotions

[15]. The student telling the story above was concerned initially that his feelings of identification with the patient were too intense and would prevent him from rendering professional care. At the same time, as an evangelical Christian, he worried about what to do with his negative reaction to the patient's homosexuality. The facts of this case had to do with rectal bleeding. The patient's situation involved universal themes of vulnerability and fear—human feelings with which the student could empathize. But engaging with the patient's "humanness" also raised judgment, even revulsion, toward a sexual orientation the student found morally reprehensible. Reconciling such conflicting emotions through the storytelling process enables students to strengthen empathy and compassion toward patients, in this way bridging gaps between differing values and life paths.

Finally, the storytelling session enables students to appreciate multiple perspectives on the same story [16]. Often two students are familiar with the same patient, and each contributes a slightly different point of view. These, combined with the insights of the "audience" (interdisciplinary faculty and remaining students) ensure that medical, emotional, psychological, cultural, and familial aspects of the story will be brought to light. Disagreements among faculty reassure students that colleagues can respectfully differ and that there is not one unitary truth to be discovered in another's story. As he told his patient's story, our medical student became more acutely aware of how the supervising resident evaluated the patient's concerns (routine), why the patient's partner perceived the situation to be so distressing (fear of cancer), and what else contributed to the patient's ambivalence about seeking care (shame).

Students are generally appreciative of the storytelling session. They comment that it gives them a much-needed "safe space" [17] to reflect on aspects of medicine not normally discussed on the wards. They also report that hearing similar accounts from their peers reduces their sense of isolation and doubt about their own professionalism. Adopting a narrative turn, even if only for an hour, connects participants with themselves and with patients, peers, and faculty. Students begin to enlarge their view of what it means to "be a doctor," to make room for exchanging stories about patients and oneself not only to advance diagnosis, but also to acknowledge and cultivate the human dimension of clinical medicine. A small minority question the value of these storytelling sessions because they emphasize exploring possibilities rather than providing answers.

When we take someone's story in medicine, we implicitly promise to handle it respectfully and with care, to always remember that it belongs to the patient, and to try help the patient rewrite it in ways that are curative, ameliorative, and healing [18]. It is essential not to appropriate another's story for one's own ends or to do violence to the story by forcing it into a preconceived framework [19]. Similarly, at the end of the session, we return the story each student told to that student, by acknowledging that, whatever insights emerged during the group discussion, it is up to the student to determine what makes sense, what he or she can learn. If the process of telling, listening, reflecting, and empathizing is effective, each story becomes richer, deeper, more complex, and more nuanced than when it was first told.

Ultimately, however, the story belongs to the student, who must decide how it will change in response to the comments and perspectives of the listeners. After we had reflected on this student's story, he was better able to see the ways in which the two stories—his and his patient's—overlapped and diverged. He was able to maintain an emotional connection with the patient without being overcome by his own fears and anxieties. By helping students to better apprehend and interpret the stories that swirl around them all day long, we hope they will become more empathic, more present, and more insightful physicians.

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# Virtual Mentor

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## MEDICAL EDUCATION

### Multiple Exposures—Reflective Writing in the First Year of Medical School

Martin Kohn, PhD, Janine Bernardo, Daniel Huck, and Eric Coble, MFA

#### Martin Kohn, Director of the Program in Medical Humanities

“Reflective practice” is one of nine competencies required of students in the Cleveland Clinic Lerner College of Medicine (CCLCM) curriculum, and writing is one means of building this reflective capacity. A systematic analysis of reflective writing research suggests a relationship between reflective insight and practice outcomes [1]. But the literature also indicates that a single feedback loop (a student writing his or her thoughts down on paper—which is to say, conversing with him- or herself only) is not sufficient and that there is much to be gained through feedback from two additional sources—mentors and peers [2]. I was intrigued by the idea of creating a fourth feedback loop that aims to build a moral community to support individuals engaged in reflective practice. Development of such a community is one of the goals advocated in a recently published Carnegie Foundation report [3]. What follows is a description of a required reflective writing experience designed to give first-year CCLCM students four kinds of feedback. The reflective writing experience is part of a curriculum that incorporates presentations, readings and performances from medical humanities, bioethics, and the creative and performing arts [4].

My goal as the new course co-director for the Foundations of Clinical Medicine (FCM) seminar was to provide a cohesive and comprehensive experience for our students. My first decision was to give an appropriate title to the seminar, changing it from the generic Foundations of Clinical Medicine seminar to *The Call of Medicine*. This change reflects one of the goals of the course: vocational identity development. The course’s multiple-block structure explores the notion that one is *called* to a life in medicine from multiple perspectives.

Four of the five thematic blocks in *The Call of Medicine*—Call of the Profession, Call of the Body, Call of Justice, and Existential Calls...Meaning in a Life in Medicine—include reflective writing assignments. A topically relevant writing prompt is assigned at the beginning of each of those blocks. The student’s written response to the prompt is sent to his or her physician mentor (small group leader), who responds, providing the second type of feedback. A third feedback opportunity occurs near the end of the seminar, when students share their reflective writing (either verbatim or in summary form) in small group sessions. The fourth feedback source is metareflective: a culminating event for all involved in the seminar presented through a work of art.

We are fortunate to have a playwright-in-residence for *The Call of Medicine*. Eric Coble, winner of the Cleveland Arts Prize and one of our nation’s leading young

playwrights, creates a dramatic piece 15-20 minutes in length that captures the experience of our students. The primary source material for his script is the (de-identified) writing produced by our students, which he combines with his own material based on the themes discussed in class. His dramatic vignette is performed by professional actors during the final session. The performance is followed by a large group discussion, which, building upon student self-critique and mentor and peer critical exchange, helps bring to a close our communal focus on one particular *call* to morally responsible practice.

In 2011, in addition to the on-campus dramatic presentations, two of the scenes were performed as part of a larger production, *Voices of Healing*, at a community arts festival sponsored by the Cleveland Play House. More than 130 people attended this performance, including approximately 15 CCLCM students. A 20-minute postperformance talkback session capped the event, providing our students additional public feedback. What follows are additional perspectives on this reflective writing experience from two first-year students and our playwright-in-residence.

**Janine Bernardo, First-Year Medical Student**

I felt uncomfortable the first time I asked a complete stranger to undo the tiny bow that held together her paper-thin gown. I felt a similar uneasiness when I peeled away the flesh of a newly deceased person. And yet there was more distress when a noncompliant patient told me why he refused to take his hypertension medication: “I don’t want to lose my erections.”

In these situations there is a common vein that runs throughout: these individuals are exposed. I saw and felt and heard things I did not think I should have. Yet, it comes with the territory; I must face these situations with compassion and honesty and respect. It is my role as a medical student.

When I first heard my words and the inner workings of my classmates exposed to an audience I felt a similar discomfort. I didn’t want to hear what worried them about medicine. Yet, just as I have begun to find ease in asking a patient to undress, I have begun to find peace in hearing the vulnerabilities of my peers, as well as sharing my own. I feel empowered when I hear the words I wrote echoed by others. I believe that it is our responsibility as students to travel to the core of our own ideas and beliefs. In doing so we disclose our strengths and weaknesses and participate in a continual journey of learning, of making better.

Exposure, I have found, is not such a bad thing.

**Daniel Huck, First-Year Medical Student**

The life of a first-year medical student can be overwhelmingly full of biochemical pathways and anatomical terminology, the components of the history and physical, and how the immune system works. Rushing from clinic to classroom, I often thought that if I could just stop for a second I would be able to figure out what it all



meant. The Call of Medicine gave me the opportunity to stop and reflect: on the first time I introduced myself to a patient as a medical student and took his blood pressure, my first day in the anatomy lab, and the first time I saw an end-of-life discussion with a heart- and renal-failure patient.

My own personal revelations become so much richer in the context of those of my peers. I reflected after anatomy lab that our medical training held the risk of our seeing patients as bodies not people. When we came together and watched a dramatization of our experiences, I saw my words melded with those of my classmates into something more than just words. As the actor, portraying a cadaver, rose and began to speak, I felt the power of a living moral community. The act of awakening opened up a dialogue: with the person inside the body, with the unspoken thoughts and feelings of my classmates, and with my own inner fears and vulnerabilities. The Call of Medicine hasn't given me all the answers, but exposed me to the diverse range of ideas and experiences of those around me. Through exposure has come awakening.

### **Eric Coble, Playwright-in-Residence**

My job, as I saw it, was to be the *aesthetic stenographer*. I attended all of The Call of Medicine seminars, took notes, talked to students before and after, trying to not only find what subjects and moments sparked a fire in me as an artist, but what repeating threads could be teased out from the presentations and conversations. I then received the reflective writing, all anonymous, all with permission to be used in a theatre piece, and set to work weaving. I scribbled in the margins, drew arrows from one text to another, finding thematic links, well-turned phrases, startling stories, while looking for what would be the most dramatic when spoken, where choral work could be used, what images should be repeated, where there were ways to physically show a moment without words—turning essays into theatre. My guiding principle was to use as much of the students' writing verbatim as I could, adding only connective tissue and incorporating some images and dialogue inspired by the previous five weeks. This was *their* mirror, not mine.

More than once, students commented how useful it was to see what their classmates were thinking—that they were not alone in their hopes, fears, confusion, and wonder. And equally important, I feel, was seeing that their classmates may be coming from radically different places and may have had dramatically different experiences doing the same task—the thoughts going through one's mind when opening a cadaver may be very common or very individual. I believe we reassured the students that they are part of a bigger community, while opening their eyes to the differences within that community—expanding their vision of themselves, their patients, and their profession.

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Janine Bernardo is a recent graduate from The College of New Jersey with degrees in biology and gender studies. She is studying medicine at the Cleveland Clinic Lerner College of Medicine and pursuing an MPH from Case Western Reserve University in Cleveland, Ohio, and is interested in an academic career in women's health or pediatric medicine.

Daniel Huck is an MD/MPH candidate at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University in Cleveland, Ohio, and is pursuing a career at the intersection of medicine and public health. Through experience in the public health field and earning a bachelor of science in physics, he has learned the importance of integrating the social and scientific sides of medicine.

Eric Coble, MFA, is a playwright and screenwriter. He is a member of the Playwrights' Unit of the Cleveland Play House in Ohio. Before turning to playwriting, Eric received his BA in English from Fort Lewis College in Colorado and his MFA in acting from Ohio University. His plays have been performed nationally and internationally.

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# Virtual Mentor

American Medical Association Journal of Ethics  
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## THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinions on Confidentiality of Patient Information

### Opinion 9.124 - Professionalism in the Use of Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

- (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- (b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
- (c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just, as they would in any other context.
- (d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
- (e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

- (f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

Issued June 2011, based on the report “Professionalism in the Use of Social Media.”

**Opinion 5.051 - Confidentiality of Medical Information Postmortem**

All medically related confidences disclosed by a patient to a physician and information contained within a deceased patient’s medical record, including information entered postmortem, should be kept confidential to the greatest possible degree. However, the obligation to safeguard patient confidences is subject to certain exceptions that are ethically and legally justifiable because of overriding societal considerations (Opinion 5.05 Confidentiality). At their strongest, confidentiality protections after death would be equal to those in force during a patient’s life. Thus, if information about a patient may be ethically disclosed during life, it likewise may be disclosed after the patient has died.

Disclosure of medical information postmortem for research and educational purposes is appropriate as long as confidentiality is maintained to the greatest possible degree by removing any individual identifiers. Otherwise, in determining whether to disclose identified information after the death of a patient, physicians should consider the following factors:

- (1) The imminence of harm to identifiable individuals or the public health
- (2) The potential benefit to at-risk individuals or the public health (e.g., if a communicable or inherited disease is preventable or treatable)
- (3) Any statement or directive made by the patient regarding postmortem disclosure
- (4) The impact disclosure may have on the reputation of the deceased patient
- (5) Personal gain for the physician that may unduly influence professional obligations of confidentiality

When a family member or other decision maker has given consent to an autopsy, physicians may disclose the results of the autopsy to the individual(s) that granted consent to the procedure.

Issued December 2000, based on the report “[Confidentiality of Medical Information Postmortem](#),” adopted June 2000. Updated December 2001.

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## Virtual Mentor

American Medical Association Journal of Ethics  
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### JOURNAL DISCUSSION

#### The Poetry of John Stone, MD

Angeline L. Wang

**Stone J. *Music from Apartment 8: New and Selected Poems*. Baton Rouge: Louisiana State University Press; 2004.**

Medicine and literature are both fundamentally concerned with the human condition, and the physician and the poet can be said to share a common goal: healing. Medicine heals the body and poetry the spirit [1].

There has long been a fascination with physician-poets, from John Keats to Oliver Wendell Holmes to William Carlos Williams [1]. Writings of physician-authors have been used in medical schools to promote humanism in medicine by encouraging students to reflect on the experiences of illness, loss, aging, and death [2] and by providing historical perspective, reminding us how much medicine has changed and how much it has stayed the same.

John Stone, a well-known contemporary physician-poet who often made medicine the subject for his work, said that writing poetry made him a better physician [1]. In the introduction to *On Doctoring*, an anthology of literature about medicine that he co-edited, Stone writes: “In the process of caring for their patients, physicians have a unique—and privileged—window on the full range of human emotions. Literature, too, is rich in its descriptions of individual illnesses and plagues, in its capacity to reveal patients’ reactions to illness and doctors’ dilemmas in providing care” [3].

Stone, a cardiologist who also served as a professor of medicine, associate dean, and director of admissions at Emory University School of Medicine, created one of the first medical school courses that combined the study of literature with medicine [4]. He began his literary career in 1972 with an anthology, *The Smell of Matches*, followed by *In All This Rain* (1980), *Renaming the Streets* (1985), and *Where Water Begins* (1998). He also produced a collection of essays, *In the Country of Hearts* (1990), which reflects on his career in medicine [4].

*Music from Apartment 8* (2004) was Stone’s final published work (he died of cancer in 2008). The collection includes 22 new poems and a “best of the best” sampling from his four previous books. His new poems are divided into three sections, one describing his adventures with his 95-year-old mother, another his memories of the Middle East, and the third his experiences growing up in Mississippi and Texas [5].

The collection showcases Stone’s lyrical language. With only a few short verses, he

is able to evoke feelings of nostalgia, hope, love, and compassion. Some of his recollections feel like memories: whimsical, multi-colored, slightly hazy on the edges, lying just out of reach. Others are deceptively simple and powerful. “After Surgery” and “Spiritual,” two of the new poems in *Music from Apartment 8*, illustrate Stone’s gift with words and imagery.

In “After Surgery,” Stone and his mother sit on the deck at her retirement community, Serenity Gardens, “rambling in childhood, tumbling/ in the sieve of memory” [6]. A physical therapist arrives:

We know why she has come:  
to stretch my mother’s tight quads,  
to lengthen her thin contracted hamstrings  
in a session worthy of the rack....

Imagine her surprise, then,  
when my mother and I rise  
from the flight deck of Serenity Gardens,  
moving aloft together, in a dream  
of a winged escape from prison [7].

These lines capture the inevitable march of age, the pain that persists and becomes part of each day—and yet cannot contain or trap imagination or spirit. The aging body will not serve as a prison for himself or for his mother. They will

...soar  
into the blue wild yonder  
on the bird bones of osteoporosis  
riding high and well [7]

beyond the reach of pain and illness. It is a reminder to those of us who care for patients that we are all more than our bodies’ limitations; we are all more than a disease.

“Spiritual” is an account of the death of Stone’s father in which the superficially clinical is deployed to heart-wrenching effect.

He died before  
coronary care  
Before the defibrillator  
  
Before lidocaine  
Monitors  
Before intensive care  
  
nurses.

They put him in  
an oxygen tent

They made the diagnosis  
just for show  
They hoped the best for him.

We let him go [8].

This poem takes us back in time—before emergency rooms, before “cath” labs—and shows us the resignation and helplessness patients and families must have felt when confronted with the limitations of what medicine could do.

The selections from Stone’s previous books include well-known pieces that have been taught in medical schools, such as “Cadaver,” “He Makes a House Call,” and “Death.” One of Stone’s shortest poems, but nevertheless still powerful, “Death” manages to capture the feeling of one moment in time.

I have seen    come on  
slowly as rust  
sand

or suddenly    as when  
someone leaving  
a room

finds the doorknob  
come loose in his hand [9].

The reader can picture the scene: a moment of surprise, of realization, and then questions of how and why. Stone takes a common and yet mysterious experience and makes it bittersweet and very human.

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# Virtual Mentor

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## CLINICAL PEARL

### The Art of Writing Patient Record Notes

Thomas Robey, MD, PhD

Do you remember the last time you read an excellent physician note? If it was similar to any of the gems I've discovered, it was well organized and included the pertinent data from the encounter, all the while keeping the patient at the center of the dialogue. Good notes facilitate continuity of care, since many physicians gather background information in the electronic medical record (EMR) prior to meeting a new patient. In a busy emergency department, discharge summaries and problem lists impart the most information in a quick read; a physician preparing for the next day's office visit benefits most from reading specialists' recent notes. The best writing takes documentation to the next level—it reveals a doctor's compassion for the patient.

Much has been written about how to write good medical notes. The SOAP mnemonic (Subjective, Objective, Assessment, Plan) introduces students to the importance of providing information in the standard manner physicians are used to. While this general outline is necessary, following it does not guarantee that the note will be any good. SOAP only dictates an order of information, not content or style. The writing task's transition from labored struggle (for students) to automatic function (for senior residents) is accompanied by improved readability. Ten admission notes in one overnight call? No problem!

Writing improves with practice. This is why the attending hospitalist efficiently enters numerous notes on one call while the new intern feels swamped by 3 admissions. Writing *well* also takes practice. To become an EMR wordsmith requires more than simple learned efficiency, a fact that is often neglected in medical education. A senior clinician once shared with me that, when it comes to the medical record, the best physician documentarians are great storytellers. For millennia, humans have told stories to make sense of the world around them. Tapping into that tradition will enrich physicians' notes, and may even improve patient care.

Trainees' notes can benefit from telling patients' stories in places other than the medical record. One easy-to-start technique I've found helpful is keeping a log of every patient I encounter. This works really well in the emergency department, where I spend most of my time. It's a bare-bones technique; every patient I see gets two or three lines in a pocket journal. The first line lists the patient's initials, gender, date seen, and chief complaint or diagnosis. On the second line, I'll note a learning point, any procedure I performed, and one other piece of the patient's story. The more random the better—captured correctly, a strange component of the interaction

can jog my memory of the entire encounter. For me, this record of pathology and molecular mechanisms is intermingled with memories of tears and laughter. Here are two examples from about 5,000 that I have accumulated since medical school:

JG061210 m AP Abscess  
I&D “Pus Volcano”

AR090808 f Fever Cellulitis  
US-guided IV in IVDU  
Forgot to listen for murmur

Of the many patients I’ve seen in the past three years, these two are among the hundred cases I could present as though I just finished talking with the patient. How can you forget a patient reporting that his abdominal pain was relieved by a volcanic eruption of pus from his belly? I *wish* I could take credit for that metaphor. The second patient provided a sobering reminder of how medical training is full of mistakes and learning opportunities. The patient was an intravenous drug user (IVDU) with cellulitis, most likely incurred from dirty injection techniques. She needed antibiotics and surgical debridement of a deep abscess. After others on the team struggled to place a line, I inserted a tenuous ultrasound-guided IV. So proud was I of that procedure, that I neglected other elements of her care—including listening for a heart murmur. Shame on me if I haven’t listened for murmurs in every subsequent IVDU I’ve treated. The visual memory of that IV slipping out as she rolled to surgery cues a vivid recall of my mistake and reminds me of the peril of hubris.

So how is it that I remember these two patients as though I just walked out of their hospital rooms? Not only did I make a record of the encounters, but within a week or so, I wrote out a narrative skeleton of the experiences. I’ve done this for about 75 of my patients, or about two a month. If you want to try this, but have writer’s block, start with the history of present illness from your SOAP note. I liked the story of the mistake well enough that I polished it for public consumption and published it on a blog I wrote for at the time [1]. Granted, I heavily edited the story both to illustrate the point of the article and to completely obscure the patient’s identity. (Which, by the way, I have done here also.)

My opinion is that the emotion born of the patient-physician interaction is sometimes too rich to leave stranded in a logbook, or worse, in the dusty caverns of my memory. Taking the time to retell patients’ stories offers an opportunity to hone writing skills that will promote understanding of their problems, improve the clarity of future notes, and in some cases help teach someone else. People who learn by seeing and doing have the added benefit that the act of writing reinforces learning. Whether the account stays in a private journal, is disseminated via blog post, or gets published on paper, it still does the job of improving the writer’s ability to tell a story. The exercise of telling your patients’ stories in plain language will help others

understand your writing, but also ground you in the narrative method that will be a boon to your medical documentation.

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Thomas Robey, MD, PhD, is an emergency medicine resident at Yale-New Haven Hospital in Connecticut. He has written columns for Medscape, blogged on his own sites and as a guest author, and edited the June 2010 issue of *Virtual Mentor*. Dr. Robey is funded by the Greenwall Foundation to study informed consent and radiation from imaging in the emergency department. He serves on the ethics committee of the Society for Academic Emergency Medicine.

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# Virtual Mentor

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## HEALTH LAW

### When Doctors Pick up the Pen—Patient-Doctor Confidentiality Breaches in Publishing

Valarie Blake, JD, MA

“I hold back nothing,” the famous confessional poet Anne Sexton once wrote, before a posthumous biography of her sparked a major debate about the limits of patient confidentiality in publishing [1].

Martin T. Orne, MD, Sexton’s psychiatrist of 8 years, released more than 300 audiotapes of private therapy sessions to Sexton’s biographer, in addition to writing an introduction to the book [2]. The audiotapes chronicled significant personal details of Sexton’s life, including her sexual abuse of her daughter, extramarital affairs, and psychotic behavior [2]. While Sexton left no instructions about what should be done with these tapes when she committed suicide in 1974, Dr. Orne and Sexton’s family felt that she would want the tapes released. Some physicians and ethicists disagreed, however, arguing that doing so violated patient confidentiality, a professional commitment that physicians make to protect patient information so that patients will be comfortable disclosing all details (even private or embarrassing details) that may be pertinent to their diagnosis and treatment [3].

Though Dr. Orne was never sued, similar court cases suggest that physicians must tread carefully when publishing patient information, even that which they have tried to de-identify [4]. This article will look at various claims patients might bring against physicians publishing confidential information and possible physician defenses.

#### Claims

*Breach of Confidentiality.* A first type of claim is breach of patient confidentiality. Contract law theory holds that a contractual relationship is established when a physician accepts and begins a patient-physician relationship. The contract encompasses an obligation on the part of the physician to keep the patient’s disclosures in confidence, and, when this confidence is broken, patients can sue for, in essence, not getting what they paid for [5, 6].

In a New York case, *Doe vs. Roe*, “Mrs. Doe” sued her former psychiatrist, “Dr. Roe,” over a book that chronicled the treatment of herself and her late husband [7]. Although the patients’ names were not included in the book and Dr. Roe had changed a number of facts, Doe argued that the inclusion of certain details—such as her son’s having published a number of operas in his youth and the remarriage of her former husband, a Harvard law graduate turned speechwriter, to a disabled lawyer—revealed her identity to acquaintances [8]. The New York Supreme Court held that

Dr. Roe had entered into a contract with her patients to keep matters in confidence and had violated patient confidentiality with the publishing of her book [9]. The court issued a permanent injunction against any distribution of the book (even to other professionals) and awarded Mrs. Doe \$20,000 in compensatory damages [10].

Plaintiffs may also sue for breach of confidentiality under tort claims. The basis for tort claims is professional malpractice—claims arise when a professional fails to uphold a standard of behavior specific to his or her profession. To succeed in a breach of confidentiality claim under tort law, a plaintiff must prove four items: (1) that a patient-physician relationship existed, (2) that the physician's conduct fell below the standard of care, (3) that there is a causal link between the physician's action and the injury to the plaintiff, and (4) that the patient suffered actual injury [11]. In defining the standard of care, courts have looked to professional ethics codes that provide guidance on patient confidentiality, like the Hippocratic Oath and the American Medical Association's *Code of Medical Ethics* [12-14]. Courts also sometimes consider medical licensing statutes here [14].

*Invasion of Privacy.* Patients may also bring a claim of invasion of privacy without consent. This tort also has four requirements: intrusion into patient privacy, appropriation of patient information, publicity that falsely represents the plaintiff in the public eye, and public disclosure of private facts [15, 16]. Courts sometimes consider both the nature and the content of such a disclosure in making a determination. Some instances in which physicians have been found justified in revealing patient information include disclosures to family members and to employers, where these parties have a legitimate interest in knowing something about a patient's condition [16].

*Physician Violation of Statute.* Physicians may be sued if they indirectly violate a state or federal law.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires health care providers and health plans that conduct business electronically to comply with certain privacy rules [17]. State laws that protect patient confidentiality vary widely. Rules that govern patient confidentiality may be spread across a variety of different statutes, ranging from those that concern public health to medical licensure or credentialing, or legal privilege regulations, and they may address a wide variety of topics, from specific diseases to autopsy [18]. Some states have codified statutes pertaining to these matters, while others rely on common law (or court cases) to provide such protections [19].

In states that have mandates against the disclosure of patient information, physicians may be sued for violating state law. States and jurisdictions that have dealt with cases under this category include New York, Washington, the District of Columbia, Nebraska, New Jersey, and Tennessee [16].

## Defenses

Physicians who are accused of wrongly revealing private patient information may have a number of defenses available to them. If the patient consented in writing to having his or her information released, for example, the right to patient-physician privilege has been waived [16].

Physicians may also claim that disclosure of the information was in the private or public interest. Private interest includes preventing harm to either the patient or others. (Relevant here is the famous case *Tarasoff v. Regents of the University of California*, in which a therapist was held to have a duty to disclose private patient information to a third party in danger after his patient informed him of intention to murder a girl and then acted on it [20].) Public interest includes information that is relevant to public health or that is newsworthy and part of the public record [21, 22].

Physicians have also claimed a right to disclose when the interest of science was at stake. In *Doe*, the physician claimed that her book was a useful resource for physicians on providing treatment to certain types of patients. The court, though hesitant to comment on the validity of her book as a medical resource, held that it did not rise to a level that trumped the patient's right to privacy [23].

Lastly, some physicians have argued that their right to free speech under the First Amendment permits them to disclose private patient information to the public. In one Massachusetts case, *Commonwealth v. Wiseman*, a filmmaker was sued for violating certain conditions he had agreed to in the filming of a state hospital. The court found that the First Amendment interest in having specialists in the fields of psychiatry and public health view the film was strong enough to outweigh patient privacy interest [24]. By way of contrast, the *Doe* court found that, because a contractual agreement to respect patient privacy was in place (given the established patient-doctor relationship), a First Amendment right to free speech did not outweigh that right to privacy [25]. One commentator has suggested that a key distinction may be whether the publication or product was intended for public benefit or not [26].

The laws concerning patient confidentiality are still being carved out by legislatures and courts, but precedent dictates that physicians must be careful in publishing information about their patients. While patients' stories may be instructive for both professional and general audiences, this interest must be balanced against society's interests in making patients comfortable sharing private information with their doctors. As legal cases have shown, physicians who reveal private details about their patients to the public may be sued for damages related to invasions of privacy, breach of contract, and the breaking of state law and may even find their books enjoined from publication. As courts continue to define the balance between a First Amendment right of free speech, the public's right to know, and protection of private information, physicians must take care to protect patient privacy in any publishing endeavor.

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# Virtual Mentor

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## POLICY FORUM

### A Delicate Balance—Ethical Standards for Physician-Journalists

Tom Linden, MD

Physician-journalists spend their working lives balancing the ethical requirements of two professions that often have competing goals. The Hippocratic oath mandates that physicians “do no harm or injustice” to their patients and “keep secret” what they “see or hear in the lives” of their patients [1].

Rather than keeping their findings secret, journalists often do the opposite—disseminating information and news to various audiences in the service of what the Society of Professional Journalists (SPJ) calls “public enlightenment” [2]. To act ethically, the journalist must adhere to the four overarching principles of the SPJ Code of Ethics: Seek truth and report it, minimize harm, act independently, and be accountable.

The possibility for conflict arises when physicians use their patients as subjects for stories. In *Awakenings* and *The Man Who Mistook His Wife for a Hat*, neurologist Oliver Sacks wove patients’ histories into compelling narratives, many of which were first published both in medical journals and popular publications including *The New York Review of Books* and the *London Review of Books* [3]. Surgeon Atul Gawande has written stories for *The New Yorker* magazine and *Slate* that were later adapted for his book *Complications*, also intended for a general audience. In his story “When Doctors Make Mistakes,” Gawande noted his concern about the confidentiality of patients and staff: “In telling this story, I have had to change some details about what happened (including the names of those involved). Nonetheless, I have tried to stay as close to the actual events as I could while protecting the patient, myself, and the rest of the staff” [4].

### Storytellers or Journalists?

Some might argue that Sacks and Gawande are storytellers but not journalists. They have points of view and make no pretense about revealing their voices and, in some cases, biases. But like journalists, they seek truth, try to minimize harm, act independently, and are accountable to their readers and editors for their reports. Gawande’s 2009 piece for *The New Yorker* magazine on geographic disparities in health care costs [5] provoked controversy when a physician at Memorial Sloan-Kettering Cancer Center in New York questioned the methodology used by the researchers Gawande cited in his report [6]. To defend his analysis, Gawande responded to the criticism in a post on *The New Yorker* website [7].

In print, physician-journalists can hide the identities of patients they profile. But each detail that advances anonymity pushes the piece closer to the gray zone between nonfiction and fiction. Stories with extensive quoted dialogue between physician and patient can strain readers' credulity. Several years ago one of my students questioned a physician-journalist about long passages of quoted dialogue in a story and wondered how the physician had recorded both his and his patient's words verbatim during an office visit. The response from the writer was troubling. He explained that the passages captured the sense of what had transpired. Ethically, that standard may work for a medical case report, but it does not work in journalism, where readers expect that what is quoted was, in fact, said. Different professions, different standards.

Physicians reporting on television confront another set of challenges, notably how to put a face—usually a patient's—on the story. When I was a practicing psychiatrist and beginning my medical television reporting career, I decided never to consult with a patient whose visit was prompted by seeing me on television. Conversely, in a television report I would never feature a patient whom I had met in the course of my practice. One can attempt to hide the identity of a patient in a print narrative, but short of shooting in shadows or electronically altering facial images and voices (all unattractive alternatives), that is not an option for television.

### **Specter of Exploitation**

Using one's own patient in a story raises the specter of exploitation even if the patient consents to be featured or interviewed. Patients may fear that refusing a physician-journalist's request will invite a denial of services or otherwise negatively affect the professional relationship. The relationship between physicians and patients is inherently unequal: physicians have superior knowledge about medicine, know intimate details about their patients, and often treat people who are vulnerable and afraid.

That's certainly the case when physician-journalists report at the sites of disasters like the earthquake in Haiti in 2010 or the earthquake, tsunami, and nuclear power plant disaster in Japan. In the days after the earthquake in Haiti, American television viewers saw physician-journalists from most of the television network news organizations—CNN, CBS, NBC, and ABC, among others—aiding victims of the earthquake and, in many cases, reporting on the people they treated. Those actions prompted me to write an essay questioning whether some physician-journalists were exploiting the vulnerable people they had treated [8]. In response, Richard T. Griffiths, vice president and senior editorial director of CNN, offered his perspective:

Like all of the CNN team in Haiti, Sanjay Gupta upheld the highest standards of journalism to convey to the world the extent of an unprecedented catastrophe. His medical expertise added extraordinary context and depth to CNN's reporting.

As a doctor, Sanjay Gupta upheld the highest standards of the medical

profession, caring for patients with compassion and skill. It's the kind of professionalism—whether doctor or journalist—of which we can all be proud [9].

### **Guiding Ethical Principles**

In the aftermath of the Haiti earthquake coverage, the Association of Health Care Journalists convened an ad hoc group of medical reporters—of which I am a member—to formulate guiding principles for reporting while “aiding those in distress” [10]. The guidelines state, in part, that “human decency prompts many journalists to offer aid and comfort to people who are suffering, but reporters must not profit from these acts nor exploit those whom they help.”

The guidelines also address the issue of consent:

People in distress who receive aid from a journalist may feel obligated to help that journalist in his or her job... If journalists have given aid, they should seek other faces for their stories....

Giving aid to people in need is natural and often commendable, but in a media environment where celebrity brings financial rewards, stories that feature journalists' aid efforts elevate their personal interests and those of their employers above the public's interest.

To avoid exploitation of patients in any venue, physician-journalists must follow a few rules. First, avoid reporting on your own patients unless consent is given freely and not under duress. Second, be sensitive to how your story will affect a patient featured in your piece. Consider an alternative narrative even if the patient consents to being profiled. Third, never feature one of your own patients in a story in which a reader, listener, or viewer can identify the individual being profiled. Finally, as the Association of Health Care Journalists notes in its online statement on aiding those in distress, “do not exploit vulnerability for gain or glory” [10].

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# Virtual Mentor

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## MEDICINE AND SOCIETY

### Vulnerability in Physicians' Narratives

Susan Sample, MFA

A man donning blue scrubs and bonnet ties a mask over his face on the cover of *Better: A Surgeon's Notes on Performance*. Turn the book over, and the physician in the photograph is recognizable as author Atul Gawande. Contrast that cover art with the front of *Final Exam: A Surgeon's Reflections on Mortality*, where two hands clasp, anonymous except for the cuff of a white coat covering one wrist. On the back, author Pauline W. Chen is pictured in street clothes. Though critics did not comment on the illustrations, they did compare the two essay collections—both published in 2007; both written by young physicians—in side-by-side reviews [1, 2]. While Gawande's work drew praise, some was tepid: "Atul Gawande is more interested in behavioral tendencies than emotional ones" [1]. "He has loaded his book with lofty-sounding ambitions, but no matter how sharp the writing," argues one reviewer, "the ultimate result is banal" [3]. Pauline Chen, on the other hand, "does do better.... Chen's elegant medical memoir offers a series of extended meditations on mortality—and by extension humanity—that stay with you long after you've finished the book" [4].

These two reviews illustrate a message that is relevant to physicians-authors as well as those considering writing about their experiences in medicine: the more personal the writing, the more personal the response. Readers, whether critics, the general public, or health care professionals, respond emotionally to physicians who, like Chen, reveal themselves literally and metaphorically through their stories. Rather than donning their professional mantles, as Gawande does, physician-authors who acknowledge their vulnerabilities as human beings "touch" their readers in the fullest sense of the word. They make contact emotionally and intellectually, and, in so doing, communicate on a most intimate level. Vulnerability is the threshold where all writers must stand to create meaningful narratives that not only help to make sense of our experiences, but also profoundly affect the lives of others.

### Powerful Threads of Personal Narratives

We live through stories, with stories, for stories. We also live out stories, ours and those of others. As medical sociologist Mike Bury notes, "The telling of stories, whether about oneself or others, is universal.... Not only do language and narrative help sustain and create the fabric of everyday life, they feature prominently in the repair and restoring of meanings when they are threatened" [5]. Physicians Tricia Greenhalgh and Brian Hurwitz situate narrative even more centrally in the practice of medicine: "Not only do we live by narrative, but, often with our doctors and nurses as witnesses, we fall ill, get better, get worse, stay the same and finally die by

narrative too” [6]. In setting out the premise for their book, *Narrative Based Medicine*, Greenhalgh and Hurwitz claim that narrative “provides meaning, context, and perspective for the patient’s predicament...a possibility of *understanding* which cannot be arrived at by any other means” [7]. Thus, they argue, physicians and especially medical students need to study narrative to better understand patients and their stories. This viewpoint is shared by Rita Charon, who has developed “narrative medicine,” a model of medical practice based on narrative competence [8]. When physicians learn to “listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient’s behalf,” they can “practice medicine with empathy, reflection, professionalism, and trustworthiness” [9].

### **Why This Story? Why Write Now?**

In the process of studying narrative, physicians, as well as nurses, social workers, and others directly involved in patient care, often find themselves writing narratives of their own. Although Charon does not delve into the writing processes of health care professionals, she does note that creating narratives is “an avenue toward consciousness, engagement, responsibility, and ethicality” [10], all noble motivations for writing personal narratives. For several years, an intensive writing workshop was held for internal medical and pediatric residents from three Yale-New Haven Medical Center training programs to determine whether creative writing would help “trainees address conflicting emotions about their professional roles and cultivate a curiosity about their patients’ lives beyond their diseases” [11]. Results showed that writing “created a sense of community among participants, enhanced both self-awareness and awareness of their patients’ lives” [11]. Along with empathy and engagement, however, an “unanticipated effect” was reported: those in the workshop experienced the therapeutic effect of writing due to “a shared vulnerability” [12]. What the medical educators evaluating the workshop seemed to have overlooked is that “stories tell us not simply what has happened, but what kind of person the narrator is” [13].

Personal narratives are personal; they reveal who we are. Returning to the book reviews cited earlier, we find Gawande, author of *Better*, described as “the Harvard-trained surgeon, writer and medical golden boy [who] thinks he has the answer” [3]. His narratives “feel less like dialogues between peers or with interested patients than guides for other MDs, how-to tracts advising them on how they too ‘might make a worthy difference’” [3]. His writing takes a “corporate” view of medicine, which aligns very well with his book’s purpose: to identify specific ways in which physicians can perform their jobs better.

Chen’s motivation for writing lies at the other end of the bell curve. She wants to explore a central paradox of medicine: how a profession dedicated to saving lives silences discussion of death, which could humanize both patient and physician. Her narratives, according to one reviewer, reveal Chen as courageous—“She tests her convictions, questions, her motives, her values, and allows herself to take pause, to listen to the patients, to their needs and frustrations”—as well as honest—“She also does not spare details on her own perceived shortcomings.... She most often uses

examples of mistakes and near-misses from her practice” [14]. It would be unfair and incorrect to equate either author with the perceptions of selected critics, but the reviews remind us that a writer’s motivation shapes not only the direction of her narrative, but public response to her story as well.

Danielle Ofri probes her own authorial motivations in a column in *The Lancet* [15]. “Writing would make me a more sensitive physician,” she muses. “I would become a better listener, more attuned to the fine details, more aware of the intricacy of the patient’s life beyond his or her presenting complaint. I would expand my focus outside of the paltry constraints of illness and appreciate the grand tapestry that is a patient’s life in its entirety” [15]. Yet Ofri is circumspect even with herself: “I think that we who write need to accept the idea that, to a large degree, we do it for ourselves” [15]. Which is not to say that such motivation is neither honorable nor admirable. On the contrary, Ofri eloquently justifies writing personal stories about patients with a rationale that reaches beyond medicine and touches the universal nature of all narrative to which Bury alludes: we should, she says, when writing always remember to “ask ourselves if we have made a connection that is healing” [15].

### **Doctor, Disrobe Thyself**

Once the surgical mask has been untied, the white coat left behind in the clinic, how does one find the threshold of vulnerability from which to write? First and foremost, Ofri calls for physician-authors to be honest: “We cannot hide behind the Hippocratic oath when our pen meets paper that is not the medical chart” [15]. The same maxim can be found in most every book discussing the craft as well as the art of writing. “The struggle for honesty is central to the ethos of the essay,” notes Philip Lopate in *The Art of the Personal Essay* [16]. “Some vulnerability is essential to the personal essay. Unproblematically self-assured, self-contained, self-satisfied types will not make good essayists” [17]. Natalie Goldberg is more direct. “*Lose control*,” she says bluntly in *Wild Mind*. “Say what you want to say. Don’t worry if it’s correct, polite, appropriate. Just let it rip” [18]. What results from writing that is candid, honest, and vulnerable is not self-centeredness, but intimacy, note Brenda Miller and Suzanne Paola: “you and the reader will find yourself in a close, if not intimate, relationship that demands honesty and willingness to risk a kind of exposure you may never venture in face-to-face encounters” [19].

It is a relationship much like that between doctor and patient. “We must probe the patient’s story as gently as we palpate their abdomen,” writes Ofri, “never going beyond the point of wincing, never causing pain for pain’s sake” [15]. Successful writing, like a physical exam, depends upon gaining trust so we may touch another. In the exam, “physician and patient are no longer strangers but are bonded through touch,” writes physician-author Abraham Verghese [20]. “That bond moves the patient toward healing—not just of the body, but of the psychic wound that accompanies physical illness.” In writing personal narratives, medical students, residents, and physicians can “understand and identify with the ambitions, sorrows, and joys of the people whose lives are put in their hands” [21] when they allow



themselves to feel. Then they can also find new meaning in their personal experiences. And, in the process of telling their stories with honesty and full self-disclosure, physician-authors can make contact with readers, touching lives in profoundly human, and healing, ways.

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## Virtual Mentor

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### MEDICAL NARRATIVE

#### *The House of God—Is It Pertinent 30 Years Later?*

Howard Brody, MD, PhD

Psychiatrist Stephen Bergman wrote the novel *The House of God* under the pen name Samuel Shem, basing it on his own experience as a medical intern at Beth Israel Hospital [1]. The novel scandalized senior physicians when it first appeared in 1978 [2]. They could not understand how a work that seemed to glamorize an unprofessional, dehumanizing attitude toward patients (not to mention containing so much bawdy sex) could become an instant hit among their house staff.

To see whether the novel tells us anything about medical education today, we must do what those early critics failed to do: get below the surface to probe the novel's satiric intent. My colleagues properly trained in literary criticism tell me that one should never assume simplistically that there's a "moral to the story" of such a complex work. I nevertheless claim that *The House of God* has a moral, and it is articulated near the end of the book by Chuck, the token African American intern: "How can we care for patients if'n nobody cares for us?" [3]

My reading of the novel is that it depicts a group of interns at a major teaching hospital who end up adopting dehumanized and unprofessional attitudes toward their patients precisely to the degree that the residency experience has treated them in a dehumanized way. If the novel has a hero, it is the Fat Man, the senior resident who tries to help the interns make it through this grueling year. He provides both emotional support and shrewd medical know-how, most of it directly at odds with the academically sophisticated but practically useless teaching of the attending staff, who care only about advancing their academic careers and not at all about the welfare of either the patients or the house staff [4].

Applying the lessons of *The House of God* today, then, prompts us to ask two questions. First, do we take better care of house staff so that they might then take better care of their patients? And second, if we do, then have those changes actually resulted in better patient care?

It seems immediately clear that many aspects of today's residency experience are considerably more humane than the world the novel depicts. Most obviously, work-hour limits have done away with much of the grueling call schedule. Most hospitals have hired ancillary staff to help with the "scut work" that used to plague medical students and interns, such as starting IVs, drawing blood, and transporting patients. Residents are paid a higher wage, though I am not sure that the amount does more than correct for inflation. Greater attention is paid to professional behavior at all

levels. If a resident today were to call an elderly patient a “gomer” (the derogatory term for demented patients that featured prominently in the novel), I expect that both peers and attendings would strenuously object.

In other ways, however, I am not sure that the house staff experience is more humane and professional than in days of old. Being a resident remains a stressful occupation. In certain respects, it has become more stressful since 1978. As hospital stays shorten, more work needs to be done in a shorter time, and only the sickest patients remain in the hospital. Do we adequately assist our residents in handling that level of stress? A truly humane environment requires opportunities to reflect on one’s experiences and discuss them with others in a supportive environment [5]. How many residencies today offer such opportunities? Are the opportunities offered across all specialties, or only in certain specialties?

The dehumanized world of the *House of God* interns carried with it at least one half-compensation: the entire world knew what it was like to be a medical intern, so no one expected these interns to perform in social roles outside the hospital—just to fall into bed and sleep. This was only a half-compensation, because, as the novel graphically shows, along with decreased expectations came decreased social support from loved ones, as personal relationships were starved. Today the social support is more robust, but the excuse is gone. Residents have family responsibilities, and no one is willing to cut them any slack—least of all themselves, as today’s young physicians wish, appropriately, to have a life outside medicine. The issues are rendered starker by the more equal gender representation among today’s house staff, quite unlike the almost-exclusively-male world that Shem portrayed in 1978. Is the residency environment doing all it can to assist young physicians in navigating these professional and personal issues? Have we figured out how to take the best care of our patients, to truly care about them, and still fulfill our responsibilities to family and friends and have time for personal nurturing? If we have figured this out, have we helped today’s residents to come to that discovery?

The degree of improvement in the residency environment over the past three decades, in sum, appears to be somewhat mixed. The next question is whether we have reason to believe that residents take better care of patients today, given that at least some of the worst abuses suffered by interns in *The House of God* seem to have been eliminated. I know of no scientific data that can answer this question, so I must resort to impressions.

I suggest, to stimulate further inquiry, that we are unable to see much overall change in patient care because of two opposing forces. If the only changes that had occurred during this time were the improvements in the residency environment, we might imagine that patient care would have become more humane. But other changes, unfortunately, are driving medicine in a different direction.

The *House of God* world was already one in which machines and procedures were rapidly replacing whatever was human in the care of patients. Roy Basch, the intern-

protagonist in the novel, falls farthest from the way shown him by the Fat Man during his ICU rotation, when he is seduced by the comforting, stress-reducing idea that medicine is nothing but applied physiology and one cares for patients by hooking them up to the right monitors and then reading the numbers off them correctly. The technocracy of medicine, especially within the hospital, has only increased since then. (I do not recall any mention in the novel of a CT scan.)

One piece of that technocracy that especially impacts the life of the resident is the electronic record. I would assume that today's residents are both far more computer-savvy than their predecessors and fully mindful of the many benefits that an electronic record might achieve in its ideal manifestation. The records that most clinicians work with on a daily basis are, however, notably distant from that ideal, and many are decidedly user-unfriendly. There are two consequences. One is that time that might be spent interacting with patients is instead spent at a keyboard. The other is that the information recorded for each patient is much more likely a matter of cut-and-paste and mouse clicks than a narrative that captures the personhood of the patient and the reality of the illness.

In conclusion, it seems hard to demand that residents ought to be more humane and professional in their interactions with their patients when we have made the entire world of medicine within which they must function steadily less humane and professional in our quest for the magic machine that will eliminate all uncertainty and grant immortality. It is far too soon to put *The House of God* in the back shelves of the library and declare the task over.

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# Virtual Mentor

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## OP-ED

### The Case History and Deferred Pain

G. Thomas Couser, PhD

After giving a lecture at another campus recently, I was approached by a graduate student (whom I'll call "Joanne" [1]), who told me the following story.

At the age of 7, Joanne was operated on for a significant physical anomaly that has required ongoing medical attention. To help her cope with the onset of this regimen, she was sent to a therapist. Nearly two decades later, learning that the therapist had been appointed to a prestigious academic post, Joanne looked her up online out of curiosity. On the therapist's resume, she found an article whose title led her to believe it was about her case. She obtained the article and confirmed her suspicion. She found reading it deeply unsettling.

This anecdote illustrates, for starters, how the Internet has shrunk our world. We all have less privacy than we used to, and it is ever easier to trace others and references to ourselves. Scenarios such as Joanne's, however, do not require the Internet: in 2001 a psychotherapy patient queried the *New York Times* ethics columnist Randy Cohen after discovering what he (or she) believed to be his (or her) case narrative while browsing in a bookstore [2]. These stories reveal that, even when authors of case studies *think* they have concealed the identity of their patients, there is no guarantee that patients will not recognize themselves should they happen upon their own narratives. And this recognition is very likely to cause them discomfort.

These therapists presumably thought they had done everything required by ethical guidelines. Perhaps they had. Joanne was far too young to grant consent to her therapist; rather than seeking it from her parents, the therapist gave her a pseudonym to conceal her identity. At the same time, Joanne's youth may have led her therapist to dismiss the possibility of her ever reading the article. And before the Internet, her doing so was far less likely. But she did, and she readily recognized it as her own case.

In addition to the advent of the Internet, the adoption of narrative medicine can also increase the likelihood of scenarios like this. With a narrative approach—which, according to Rita Charon, elicits “accounts of self not limited to physical aspects of the body but that include emotional, familial, aspirational, creative aspects of the self”—a physician's relation to her patients moves closer to that of a psychotherapist [3]. This may serve the patients' interests; that is the aim (and claim) of narrative medicine. But greater knowledge of patients' lives also facilitates and encourages the writing of case studies. Indeed, in a paper delivered at the Modern Language

Association convention in January 2011, Charon, one of its foremost advocates, eloquently addressed the dangers inherent in narrative medicine. Her title—“Listening, Telling, Suffering, and Carrying On: Reflexive Practice or Health Imperialism?”—indicates the prospect that, rather than empowering patients, this approach will only extend the power of clinicians [3]. It may also increase the risk of what I call “deferred iatrogenic pain”—emotional hurt inflicted on patients not by their treatment but by their case narratives.

The point is that even heeding ethical guidelines does not preclude the possibility that case histories will cause pain to their subjects. That pain may not rise to the level of manifest “harm,” and the clinicians may not have violated the precept “First, do no harm.” But in Joanne’s case, the pain was far from negligible, despite being long delayed. And it may have been avoidable.

Perhaps not; it may not always be possible to conceal patients’ identities from them. The very details that distinguish cases sufficiently for them to make a contribution to the medical literature may also enable patients to recognize them as their own. In any event, among the potential readers of case studies, patients (and those close to them) are uniquely equipped to know *all* the identifying details *and*, of course, who provided treatment.

If their rights have not been violated, the question is whether their pain is outweighed by the benefits of writing the narrative. The question *then* becomes *cui bono*? Who—or what—benefits? Presumably, the goal of writing case histories is to advance the understanding of particular conditions and improve their treatment. Thus, the case history serves the common good, the welfare of all—the public health. At the same time, there are undeniable personal and professional benefits to the *author* in committing a case to print. Doing so can build the author’s reputation and advance his career—and lead to monetary gain. Consider the example of Oliver Sacks, the world’s most famous neurologist, whose fame (and fortune) is based not on his record of treating patients or on his contributions to neurology but on his many nonclinical case studies of unusual syndromes [4]. So the medical professional may not be in the best position to judge the advisability of writing up a particular case. Indeed, the writing of case studies entails a conflict of interest: authors stand to gain from them in a way that is not true for their subjects. This can affect their judgment of the *medical* benefits of such projects.

I cannot speak for Joanne; indeed, she is struggling to understand just why she was so troubled by reading her case. But I think that a patient’s discomfort could be a function of the intrinsic disparity between the patient’s and the clinician’s relations to a case. The patient comes to the clinician in the hope of help—of *care*, if not of cure. To the professional, however, the patient represents an instance of something beyond herself, perhaps a disease or impairment in which the professional has an intellectual interest or is carrying out a research program. The hurt caused by a patient’s self-recognition may arise from the feeling that one has been reduced to one’s condition and thereby objectified.



What disappoints and offends a patient who reads her own case narrative, then, may be the discovery that she is not just a person, or a patient, but also a *case*—indeed a case *of*—to her therapist or physician. The psychotherapist Ruthellen Josselson has acknowledged this. Confronted with negative reactions by her patients to their case histories, she came to this realization:

I [had], in a sense, been talking about them behind their backs and doing so publicly. Where in the interview I had been responsive to them, now I [was] using their lives in the service of something else, for my own purposes, to show something to others. I am guilty about being an intruder and then, to some extent, a betrayer [5].

Thus, the patient who reads her own case may make the uncomfortable discovery that, in the therapeutic relationship, her well-being was not the *only* end: she has also been a *means* to an end. Whether she values that end depends on what she takes it to be. If she sees her case as being used to advance knowledge of her condition, she may decide her discomfort is justified. If she sees the end as careerist, she may not.

I would advise medical professionals, then, to err on the side of caution. It may not be enough to take the precaution of concealing a patient's identity—or obtaining consent. The patient who gives consent has perhaps no idea what it would be like to come upon her story in alien discourse. So it may be advisable to assume that one's patient *will* in fact read the narrative of her case and recognize it as her own. And to write accordingly, if one writes. And not to write, if one believes it will cause too much discomfort.

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G. Thomas Couser, PhD, retired in 2011 from Hofstra University on Long Island, New York, where he was a professor of English and founding director of the disability studies program. His books include *Recovering Bodies: Illness, Disability, and Life Writing* (Wisconsin, 1997), *Vulnerable Subjects: Ethics and Life Writing* (Cornell, 2004), and *Signifying Bodies: Disability in Contemporary Life Writing* (Michigan, 2009).

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## Suggested Readings and Resources

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# Virtual Mentor

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