

The Ethics of Professional-Patient Boundaries: Everything I know, I learned at County

Stroger Hospital of Cook County Medicine Grand Rounds
3/8/2013

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Financial Conflicts/Disclosures

- Commercial -NONE
- Other/Grant Funding
 - AHRQ PROMISES Ambulatory Safety & Malpractice Grant
 - AHRQ -BWH CERT HIT – Adverse Drug Reaction detection and UIC Patient Safety CERT
 - Harvard Risk Management Foundation (CRICO) – Dx Errors
 - FDA - CPOE Errors Evaluation (CPOEMS)
 - Commonwealth Fund –Medical Home Evaluation
 - ONC –RAND- Clinical Decision Support Taxonomy

Outline –

Professional-Patient Boundaries

- Audience response poll – 4 scenarios
- Patient presentation: County ASC-GMC pt
- Critically review prevailing boundary paradigms
 - Historical and current context
 - How issue relates to your/our work
 - Relate to various quality/safety projects
 - Practical ideas/suggestions
- Q&A

Audience Poll- 4 Scenarios

For each scenario

- A. Have you ever done something similar to this?
- B. Is it acceptable to do something like this?

Scenario #1 – Giving Pt ride home

- The medical practice running late resulting in a poor patient missing a ride home. It is raining, no good public transportation is available and the physician knows that the patient's house is along his/her route home. MD offers to drive patient home

Scenario #2 – Giving \$ to help pay for med

- It is late Friday afternoon and the treatment team has exhausted all means of getting needed medication renewal covered by insurance for an indigent patient. MD reaches into own pocket and gives patient \$30 to pay for the medication

Scenario #3

Help find job ex-prisoner

- A patient who was recently released from prison is having difficulty finding employment. Based on a clinical assessment that patient has been successfully rehabilitated from drugs and is reliable, the physician contacts a friend who owns a hardware store to inquire (and advocate for) if any job is available working in the hardware store.

Scenario #4 – Employing a Pt

- A patient is unemployed for the past 18 months, unemployment benefits now have run out, and unable to pay rent and about to become homeless. MD offers patient 6 hours per week temp job doing (non-patient related) filing and office work to help pay rent.

- **POLL RESULTS**

	EVER DONE ?		
	Brigham	Cambridge	County
Ride Home	17%	44%	51%
\$\$ for Med	21%	62%	60%
Help Find Job	22%	13%	33%
Temp Job	4%	6%	12%

ACCEPTABLE ?

	Brigham	Cambridge	County
Ride Home	55%	88%	82%
\$\$ for Med	50%	75%	89%
Help Find Job	42%	44%	96%
Temp Job	35%	25%	79%

Raises Fundamental Questions

- Are Cook County, Cambridge, Brigham different
– And should they be?
- Nature of our “relationships” with our patients
- How can we more fully, effectively, deeply care for our patients
- What are boundaries we should vs. should not cross
- How does this relate to social and historical context of what is happening in in medicine and society today

ASC Meeting; Job Helping me in my office

- Just released from prison; drugs
- Walk-in Clinic for HBP meds
- Referred to my General Med Clinic
 - “..cared about more than medicine”
- Offered temp job filing, packing boxes
 - Appreciation being given “2nd chance”



Successful Referral for Employment

- Referred, advocated for job
 - Driver for his vacuum repair business
- Pride in being “best driver ever”
- Working there past 6 years



Reunited, Reconciled w/ 2 Daughters

- Resume role as “dad” and financial support
 - Kids used to see me as a just a drug addict”
- Surprise news:
 - Daughter’s graduation
 - Bachelors in criminal justice
- Desire to “repay debt to society”



Is there a label/name for what we are talking about?

- Personal relationships w/ patients
- Enhanced caring relationships
- Caring for the “whole person”
- Going the extra mile
- Patient- centered care (“extreme”; “concierge”)
- Extending helping-hand to those most in need
- Crossing boundaries where compelling reasons
- Solidarity beyond charity
- Normal human empathy and compassion

- “How do you teach empathy -- you don't need to --you just enhance it--you don't need to teach it since it's already inside of us.”

So What's the Problem/Issue

- Controversial, contentious, issues
- Painful choices for providers
- “Demanding/difficult” patients
- Time- more and more stresses
- Personal painful questions raised about at my hospital about my actions
 - Face-to-face w/ questions challenged me to think deeply about issues.

Re-thinking Prevailing Wisdom

- Decisions to extend hand needs to be contextual and caring rather than *inflexible* and *arbitrary*
- Like rest of medicine balance risk-benefit
 - Need to weigh, minimize risks, maximize benefits
- Historical context
 - Understanding 1970-90s; vs. 2012
- Renewing our professionalism, humanity
 - Laying groundwork for different more caring approach
 - Call for more honesty, transparency, fairness
 - Charity vs. solidarity?

Potential Risks

from extending hand to help needy pts

Practical Problems

- Expect repeated help
- Become dependent; impair own resourcefulness
- “Divert” \$ buy/sell drugs/alcohol
- Other pts will expect similar
- Distracts from medical needs (screening)
- Takes away from care/time of other patients

Broader Concerns

- Legal liabilities (car accident)
- Injurious to objectivity
- Potential for privacy violations
- Excessive demands profl’s time
- Burnout; over-involvement
- Staff dynamics, differing abilities
- Exploit needy pts, unequal power relationships
- Transference, coercion, perceived obligation, burden
- Opens door to sexual relationship

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Opinion 10.015 - The Patient-Physician Relationship

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient (or surrogate). In some instances the

Opinion 10.015 - **The Patient-Physician Relationship**

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.

Potential “Medical” Benefits

- Rapport, trust building, conveying caring
- Promotes continuity
- Enhanced communication
- Learning more about patient
- Therapeutic alliance; development, negotiation realistic therapeutic plan
- Adherence to recommendations/plan
- Synergies w/ supportive counseling (“words the can heal”)
- Pt more comfortable sharing info; empowered to speak up, seek out care, access services when needed
- Enables access/advocacy for community services
- **“Co-producing” diagnosis**

Finding and fixing diagnosis errors: can triggers help?

Gordon D Schiff

Imagine conferring with your clinician colleagues and being handed a plateful of all of your missed and delayed diagnoses. But, imagine further that, rather than a nightmare of ghosts returning to haunt you in the form of malpractice claims, sanctions by regulatory boards, insurers pouncing on needless expenditures or hordes (yes, there would be large numbers) of angry finger-pointing patients and families, the experience would instead bring a dream of supportive feedback and learning. Imagine the ways such an idealised non-threatening consultation and conference might be designed to minimise defensiveness and maximise introspection, learn

I suspect the average clinician could care less about diagnostic ‘triggers’ or a new study to increase their positive predictive value. However, no professional could fail to see the appeal of the ultimate form of continuing medical education imagined above—learning practical lessons from one’s own cases and discussing with trusted colleagues the ways care could be improved. How to get there from here poses a fundamental challenge, one that the study by Singh *et al* on diagnosis error ‘triggers’ in this issue of *BMJ Quality and Safety* attempts to address.¹

The authors, a research team based at the DeBakey Veterans Affairs

promise of facilitating qualitative leaps forward in what we can learn from the details of clinical care processes and outcomes.

As the authors and the literature repeatedly point out, diagnostic errors are important but understudied, largely because of difficulties in defining and detecting such errors.^{3 4}

Can generic electronic screens cast an effective and efficient net to pick out/up charts to review for errors in diagnosis with a sufficiently high likelihood of errors (ie, positive predictive value) to make the manual reviews worth the effort? In attempting to ease the burden of detecting diagnostic errors, the authors (and others) have sought to develop methods to more efficiently sift through the tens of thousands of encounters they wanted to screen for diagnostic errors. In the present study,¹ they developed two relatively simple screens—admission to an acute care hospital in the 14 days

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CHAPTER 8

Diagnostic Errors

Gordon D. Schiff, MD
Mark L. Graber, MD, FACP

INTRODUCTION

A diagnostic error is any mistake or failure in the diagnostic process leading to a misdiagnosis, a missed diagnosis, or a delayed diagnosis. This is an operational definition that includes any failures in the process of care, including timely access in eliciting and interpreting symptoms, signs, or laboratory results; formulating and weighing differential diagnosis; or lack of timely follow-up and specialty referral and evaluation. A diagnostic error is a construct that is usually based on reference to a subsequent test, clinical outcome, consultant's diagnosis, or autopsy—gold standards that are themselves often imperfect or unavailable. Errors in diagnostic related processes are ubiquitous, ranging from a trivial failure to ask an “insignificant” historical question to overlooking minor laboratory abnormalities, to switching specimens between two patients, to more serious errors in interpretation of data, which may or may not have adverse clinical consequences in terms of labeling a patient with an erroneous diagnosis or impacting clinical action or outcomes. Detecting diagnostic errors is critical to correction of the ongoing care for a current patient, as well as for learning how to avoid similar errors in the future.

Although there is a paucity of data on the prevalence of diagnostic errors in everyday practice, studies using a wide range of approaches suggest that the error rate is not small, conservatively 10–15% for many diagnoses. Selected examples and rates from these studies are summarized in **Table 8-1**. These studies, however,

Commentary: **How Can We Make Diagnosis Safer?**

Academic Medicine 2012

Gordon D. Schiff, MD, and Lucian L. Leape, MD

Abstract

Diagnostic errors are common and are a leading cause of patient dissatisfaction and malpractice suits. Because of its traditional heavy reliance on memory and lack of standardization, the diagnostic process is particularly error prone. A study by Zwaan and colleagues on diagnostic failures in treating dyspneic patients makes several important contributions: examining the process behind the diagnosis, seeking insights as to the reasons for the process failures by interviewing the treating physicians, and using the Delphi process with experts to map the optimal diagnostic process.

There is considerable confusion about definitions in the field of diagnostic errors. The authors of this commentary use a Venn diagram to clarify distinctions and relationships between diagnosis processes errors, delayed diagnosis and misdiagnosis, and adverse outcomes. A key question is whether a much more rigorous process should be employed for diagnosis, specifically the routine use of algorithms or guidelines, and whether barriers to achieving it can be overcome.

The authors propose an alternate simpler approach: six-part checklists for the top 20 or 30 clinical symptoms or problems. The elements of these checklists for

minimizing diagnostic errors include essential data elements, don't-miss diagnoses, red-flag symptoms, potential drug causes, required referral(s), and follow-up instructions.

These checklists could—and should—be developed by collaborative efforts of the main users, primary care physicians, and emergency physicians, working with specialist physicians on specific symptoms and diagnoses. Absent such professional commitment, progress in diagnostic accuracy is likely to be slow.

Editor's Note: This is a commentary on Zwaan L, Thijs A, Wagner C, van der Wal G, Timmermans DRM. Relating faults in diagnostic reasoning with diagnostic errors and patient harm. Acad Med. 2012;87:149–156.

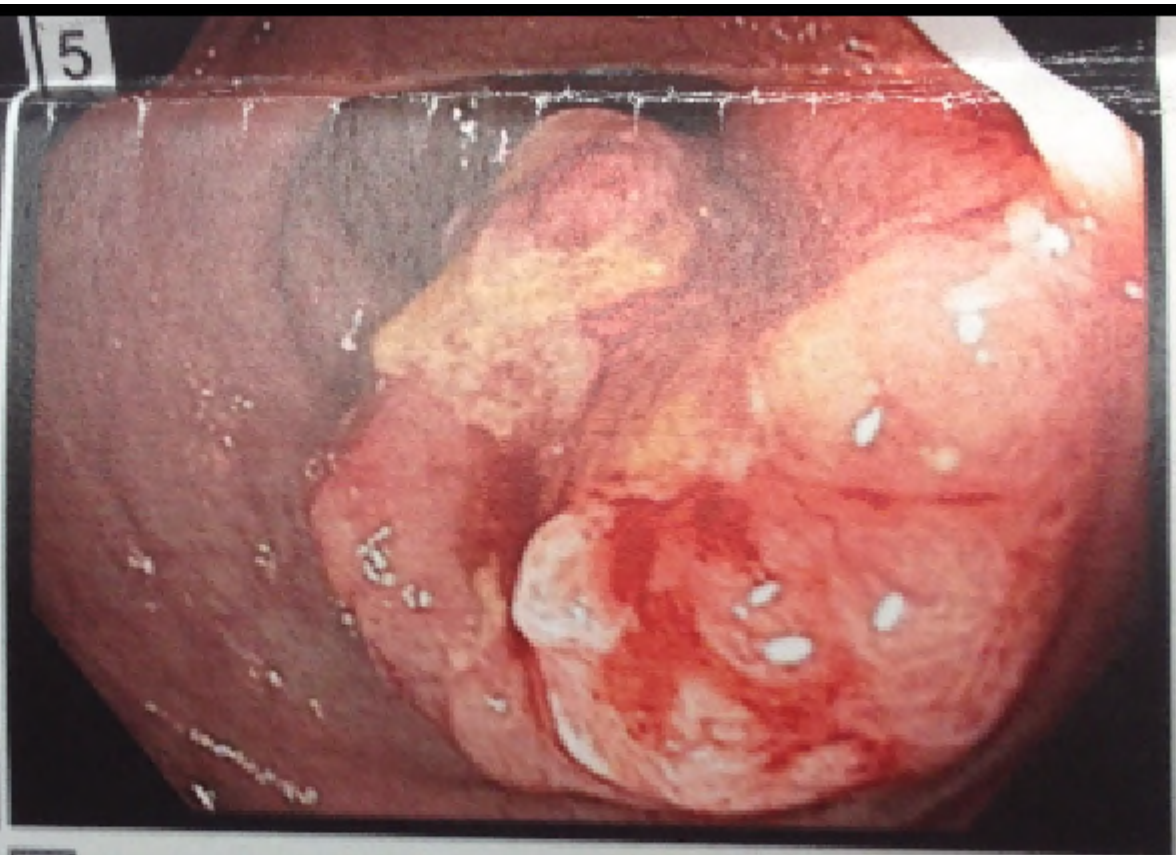
diagnostic process is predictably error prone. It relies heavily on human memory, lacks systematic feedback systems, is highly idiosyncratic with widespread practice variations, and is plagued with difficulties in sorting out the signal of rare serious diagnosis from

not result in a serious diagnostic error or patient harm, but the frequency and variety of the defective processes is disturbing.

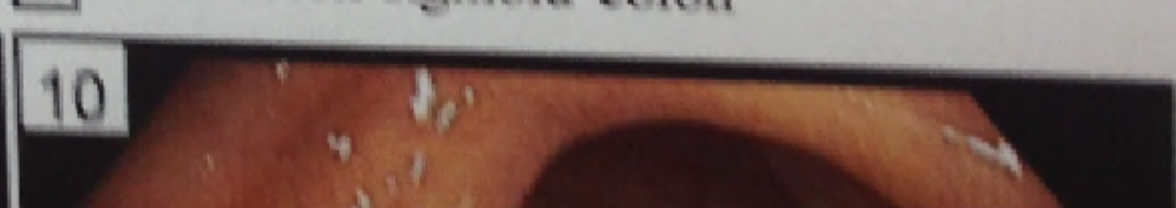
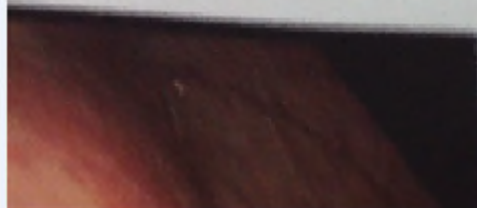
After the charts were reviewed and suboptimal diagnostic processes



sigmoid junction



5 tumor-colon-sigmoid colon

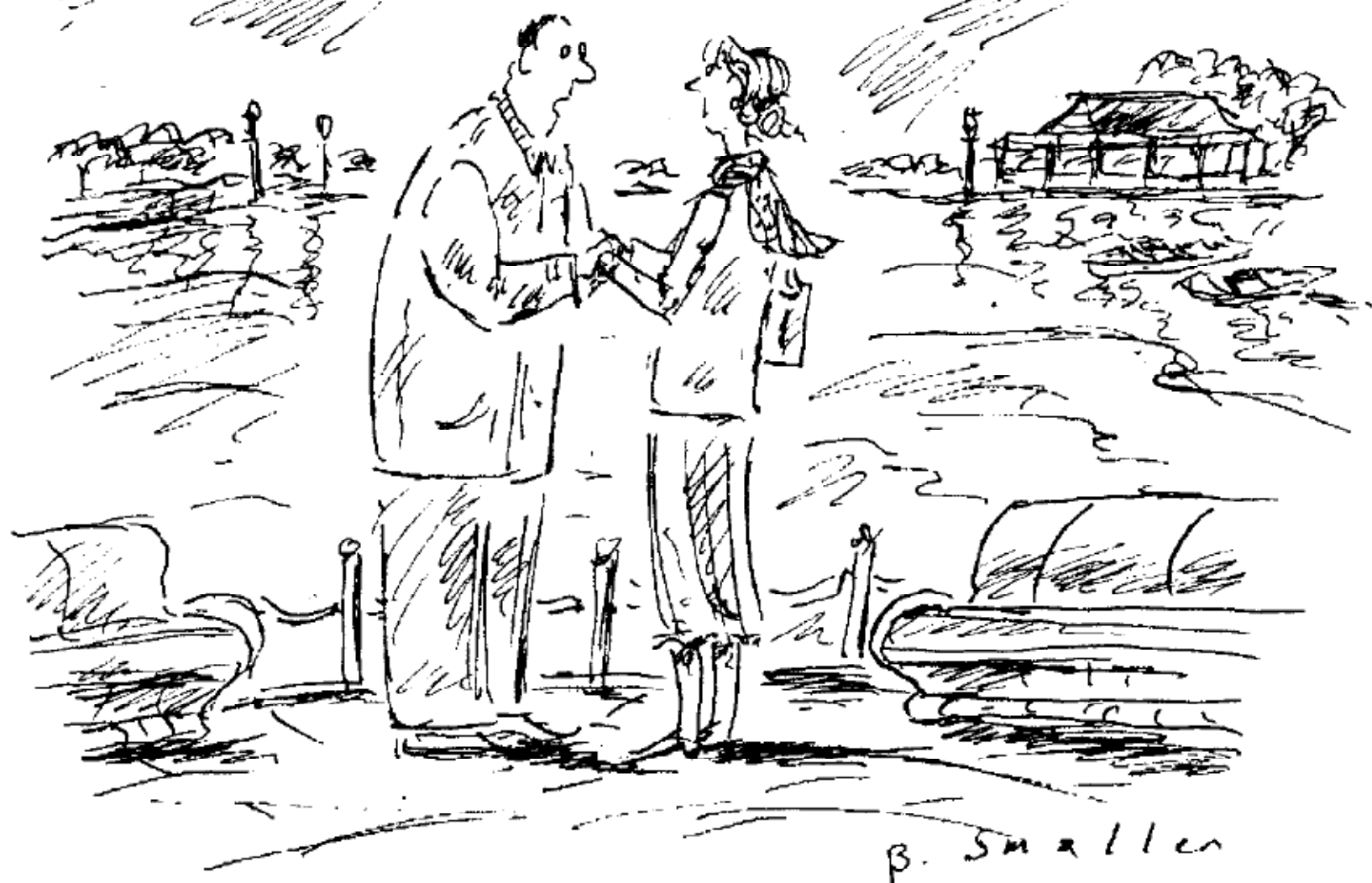


10

But more than just
“medical” needs/benefits

Every time we say “no” to a needy patient,
do we lose a bit of our professionalism,
a bit of our humanity?

- It's not my job
- I'm too busy
- I don't trust you
- I'm not allowed to help you
- Let the social worker deal with it
- That's not what medicine is about
- As a professional, best not to get involved
- I know you're suffering but nothing I can do



"I'm afraid if I open up and get close to someone, they'll ask me for money."

An ethicist's journey as a patient: are we sliding down the slippery slope to sloppy healthcare?

Melissa McCullough

BMJ Quality & Safety 11/11

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ABSTRACT

People who are sick are often the most vulnerable in society. They frequently rely on caring and competent healthcare professionals and should and do have expectations of a safe and caring environment. In a recent unexpected system, the organisation's compassion and humanity were a very short story. Any form of dehumanising service that leads to treatment not on human rights but as a by-product

that they thought I had a somewhat rare disorder called a 'syringomyelia', a cyst-like tumour in my spine or brain. If it was as they suspected, they informed me that the damage

Bad experiences in the hospital: the stories keep coming

Wendy Levinson,¹ Kaveh G Shojania^{1,2}



EDITOR'S
CHOICE

Most people facing us all in the NHS's include increased access to community job losses. D

In this issue of the journal, two patients narrate stories about their disappointments with a healthcare system that did not seem to care about them as people. Michel Villette, a sociologist in France, tells the story of his hip surgery in an

delivery.^{6 7} Why do these stories of bad patient experiences continue to appear from every health care system?

Broadly, these stories illustrate gaps in quality in the dimension of 'patient-centred care', one of the six dimensions of quality in the Institute of Medicine definition.⁸ Metrics of

But, the author of the overwork members are inability to p they know is broken 'four' illustrates the nu just the p malfunctioni bothered bo doctor to who If these gaps to both heal patients, wou benefits to b We believe

Patient perspective

For want of a four-cent pull chain

Michel Villette

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A noted French ethnographer describes his care in a French private hospital for a hip replacement. He recounts a number of events that are probably typical of many patients' hospital experiences, but which clinicians often do not perceive. The observations are probably similar to those patients might make after exposure to any modern healthcare system, except that they offer a level of detail few would provide. The account focuses on the contradiction between excellent technical operations and the absence of compassionate patient care, basic civility and the needs of patient safety. It addresses marketing of hospital services, staffing levels, conflicts between private enterprise and medical need, fragmented billing, disconnected after-care, and the absence of a coherent view of a patient's experience—the non-coordination of care. The author is not an expert in healthcare, and so refrains from offering specific recommendations, but hopes that his expe-

The staff seemed perpetually elsewhere, carrying out other prescribed duties.

In telling my story, I make no pretence of representing the views of the hospital administration. Nor do I point to any remedies. My purpose lies in inviting readers to reflect on the philosophy of care underlying the modern care organisation and stimulating thoughts about improvement.

ADMISSION

When it became clear I needed surgery to replace my hip, I chose this private hospital simply because of its location—next door to my home. I was also aware that the hospital specialised in orthopaedics and enjoyed a good reputation. Moreover, my mother and daughters had successfully undergone treatment there. While some public hospitals in Paris would doubtless have offered at least the same promise (and lower costs), I did not pursue other options.

- “When the patient asked for something that did not exactly conform to their job description, they sought to ignore the requests.”
- “....what I noticed was that staff seemed to be so overworked and overwhelmed by their duties that they had no time or energy to deal with anything other than their basic duties. Despite good intentions, they couldn't address the plethora of problems a vulnerable patient encounters.”

Key Historical Contexts

1970s-90s – Boundaries Construct

- Documentation/scandals especially psychotherapists, others sexual relationships w/ patients
 - ~10-12% M; 4% F
- Feminist critiques of medical power abuses
- Adoption various “zero tolerance” codes

Professional Boundaries in the Physician-Patient Relationship

Glen O. Gabbard, MD, Carol Nadelson, MD

THE SUBJECT of professional boundaries (and boundary violations) has received a great deal of recent attention in the psychiatric literature.¹⁻⁵ The emphasis on defining guidelines for professional conduct has expanded beyond the confines of ethics committees and has worked its way into licensing boards charged with disciplining physicians whose behavior jeopardizes the well-being of patients. The Massachusetts Board of Registration in Medicine,⁶ for example, has recently issued detailed guidelines on such matters as self-disclosure, dual relationships, sexual relationships with patients, and other professional boundaries to help define for the public and for the profession the parameters of professional conduct in the practice of psychotherapy by physicians. While specialists in psychiatry have been debat-

of course, includes refraining from sexual involvement with patients. While sexual contact is perhaps the most extreme form of boundary violation, many other physician behaviors may exploit the dependency of the patient on the physician and the inherent power differential. These include dual relationships, business transactions, certain gifts and services, some forms of language use, some types of physical contact, time and duration of appointments, location of appointments, mishandling of fees, and misuses of the physical examination. The transgressions of some of these boundaries may at times be necessary and helpful. For example, it would certainly be appropriate to hold the hand of a patient who reaches out to a physician after losing a family member. One can differentiate minor boundary crossings

As a result of the intense concern that has been generated by sexual exploitation in the physician-patient relationship, much more research has accumulated on sexual boundary violations than on nonsexual boundary violations. Hence, our discussion of professional boundaries will begin with a consideration of sexual misconduct and progress from there to an examination of other forms of professional boundary transgressions.

Sexual Boundary Violations

Six studies⁸⁻¹³ have sought to determine the prevalence of sexual misconduct in the physician-patient relationship (Table).

A comparison of the US studies with the survey from the Netherlands and with the studies from Canada suggest that the



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Arguments for zero tolerance of sexual contact between doctors and patients

R M Cullen *Avondale Family Health Centre, Avondale, Auckland, New Zealand*

Abstract

Some doctors do enter into sexual relationships with patients. These relationships can be damaging to the patient involved. One response available to both

clusion that can be drawn is that such sexual relations are "ill advised" and "hazardous".¹

The third argument is Aristotelian in origin. It considers the virtues necessary in a good medical

Key Historical Contexts

2013 – Boundaries Current Status/Issues

- Consensus: no sexual contact
 - Debates re: former pts
- ↑ Strains on doctor-pt relationship (time, etc)
 - Corporatization, commercialization of relx
- “Patient-Centered” care/Medical Home
- Increasing awareness/oversight gifts to MD’s
- Growing disparities, poverty, unemployment

Primary Care Practice Development: A Relationship-Centered Approach

William L. Miller, MD, MA

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Ann Fam Med 2010

ABSTRACT

PURPOSE Numerous primary care practice development efforts, many related to the patient-centered medical home (PCMH), are emerging across the United States with few guides available to inform them. This article presents a relationship-centered practice development approach to understand practice and to aid in fostering practice development to advance key attributes of primary care that include access to first-contact care, comprehensive care, coordination of care, and a personal relationship over time.

METHODS Informed by complexity theory and relational theories of organizational learning, we built on discoveries from the American Academy of Family Physicians' National Demonstration Project (NDP) and 15 years of research to understand and improve primary care practice.

RESULTS Primary care practices can fruitfully be understood as complex adaptive systems consisting of a core (a practice's key resources, organizational structure, and functional processes), adaptive reserve (practice features that enhance resil-

What ‘Patient-Centered’ Should Mean: Confessions Of An Extremist

A seasoned clinician and expert fears the loss of his humanity if he should become a patient.

by **Donald M. Berwick**

ABSTRACT: “Patient-centeredness” is a dimension of health care quality in its own right, not just because of its connection with other desired aims, like safety and effectiveness. Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it. Such a consumerist view of the quality of care, itself, has important differences from the more classical, professionally dominated definitions of “quality.” New designs, like the so-called medical home, should incorporate that change. [*Health Affairs* 28, no. 4 (2009): w555–w565 (published online 19 May 2009; 10.1377/hlthaff.28.4.w555)]

THE CONCEPT OF THE MEDICAL HOME (a practice team that coordinates a person’s care across episodes and specialties) is now reaching center stage in proposals for redesign of the U.S. health care system.¹ The major primary care societies—the American College of Physicians, the American Academy of

What Do Physicians Tell Patients About Themselves?

A Qualitative Analysis of Physician Self-disclosure

Mary Catherine Beach, MD, MPH, Debra Roter, DrPH, Susan Larson, MS, Wendy Levinson, MD, Daniel E. Ford, MD, MPH, Richard Frankel, PhD

JGIM 2004

OBJECTIVE: Physician self-disclosure (PSD) has been alternatively described as a boundary violation or a means to foster trust and rapport with patients. We analyzed a series of physician self-disclosure statements to inform the current controversy.

DESIGN: Qualitative analysis of all PSD statements identified using the Roter Interaction Analysis System (RIAS) during 1,265 audiotaped office visits.

SETTING AND PARTICIPANTS: One hundred twenty-four physicians and 1,265 of their patients.

MAIN RESULTS: Some form of PSD occurred in 195/1,265 (15.4%) of routine office visits. In some visits, disclosure occurred more than once; thus, there were 242 PSD statements available for analysis. PSD statements fell into the following categories: reassurance ($n = 71$), counseling ($n = 60$), rapport building ($n = 55$), casual ($n = 31$), intimate ($n = 14$), and extended narratives ($n = 11$). Reassurance disclosures indicated the physician had the same experience as the patient ("I've used quite a bit of that medicine myself"). Counseling disclosures seemed intended to guide action ("I just got my flu shot"). Rapport-building disclosures were either humorous anecdotes or statements of empathy ("I know I'd be nervous, too"). Casual disclosures were short statements that had little obvious connection to the patient's condition ("I wish I could sleep sitting up"). Intimate disclosures refer to private revelations ("I cried a lot with my

Physician self-disclosure, defined broadly as any statement made to a patient that describes the physician's personal experience,¹ is a controversial communication behavior. Physicians' personal revelations to patients have been alternatively described as a boundary transgression² or as a way of fostering trust and rapport in the patient-physician relationship.³⁻⁷ In terms of self-disclosure's potential for boundary violation, a special report on boundaries in the patient-physician relationship describes physician self-disclosure as a common starting point down the slippery slope toward a sexual relationship with a patient. The authors report "even if revealing personal issues to a patient does not lead progressively to more extreme boundary violations, self-disclosure is in itself a boundary problem because it is a misuse of the patient to satisfy ones' own needs for comfort or sympathy."²

In contrast, others have described physician self-disclosure as an opportunity for fostering intimacy, trust, and reciprocity between doctors and patients.³ One study reports that viewers of a health counseling video in which a physician discloses his/her own positive health behaviors considered the physician to be more credible and more motivating regarding diet and exercise than in a similar

- 1264 primary care visits to 24 MDs
- 242 “personal disclosure” statements
- Mostly rapport-building and reassurance

“Fear that physician self-disclosure to patients will lead down a slippery slope to more extreme boundary violations seems unsubstantiated in visits we studied. In routine office practice of primary care physicians and surgeons, the overwhelming majority of disclosures do not appear to represent a danger to patients”

Boundary Violations or Broadening Repertoire ?

- Home visits
- Attending funerals
- Taking extra time from schedule
- Giving pager, cell, home phone
- Sympathetic ear, not their fault
- Writing letters support for jobs,
- Bike rides: sponsor, go together
- Walking to appointment
- Driving home
- Community meetings
- Weddings, bar mitzvahs, graduations, events at home
- Share music, books, sports, food recipes, other interests
- Waiving co-pays
- Giving/lending money for bus-fare, sandwich, med co-pay, house fire
- Advocacy for social services
- Helping obtain disability benefits
- Appealing denials
- Help overcome medication obstacles: short term refills, insurance glitches,
- Introducing pts to each other peer support
- Help get dignified jobs/work
- Helping pt's family members: kids on drugs help w/referrals

ONLINE FIRST | LESS IS MORE

Principles of Conservative Prescribing

Gordon D. Schiff, MD; William L. Galanter, MD, PhD; Jay Duhig, MA; Amy E. Lodolce, PharmD, BCPS;
Michael J. Koronkowski, PharmD; Bruce L. Lambert, PhD

Judicious prescribing is a prerequisite for safe and appropriate medication use. Based on evidence and lessons from recent studies demonstrating problems with widely prescribed medications, we offer a series of principles as a prescription for more cautious and conservative prescribing. These principles urge clinicians to (1) think beyond drugs (consider nondrug therapy, treatable underlying causes, and prevention); (2) practice more strategic prescribing (defer nonurgent drug treatment; avoid unwarranted drug switching; be circumspect about unproven drug uses; and start treatment with only 1 new drug at a time); (3) maintain heightened vigilance regarding adverse effects (suspect drug reactions; be aware of withdrawal syndromes; and educate patients to anticipate reactions); (4) exercise caution and skepticism regarding new drugs (seek out unbiased information; wait until drugs have sufficient time on the market; be skeptical about surrogate rather than true clinical outcomes; avoid stretching indications; avoid seduction by elegant molecular pharmacology; beware of selective drug trial reporting); (5) work with patients for a shared agenda (do not automatically accede to drug requests; consider nonadherence before adding drugs to regimen; avoid restarting previously unsuccessful drug treatment; discontinue treatment with unneeded medications; and respect patients' reservations about drugs); and (6) consider long-term, broader impacts (weigh long-term outcomes, and recognize that improved systems may outweigh marginal benefits of new drugs).

Arch Intern Med. 2011;171(16):1433-1440.

Published online June 13, 2011.

doi:10.1001/archinternmed.2011.256

Provocative Quotes from other Health Professionals

- Stop going to hardware store if owner becomes my patient?

I WOULD GO OUT OF MY WAY TO GO TO THAT HARDWARE STORE

- There's one big problem with lending money to patients

....THE PATIENTS ALWAYS REPAY ME

- View of Phyllis Jen (via husband Bob Schlauch)

***THE LAWYERS HAVE DRIVEN US FROM
OUR OWN HUMANITY***

- Glenn Gabbard, author of JAMA guidelines

***WE WROTE THESE ARTICLES AND
GUIDELINES TO KEEP DOCTORS
FROM EXPLOITING PATIENTS, NOT
FROM HELPING PATIENTS***

- I love taking care of patients. It is one of the most fun things I do. My patients invite me into their lives as I teach them how to take care of themselves and get what they need. These experiences are often deeply moving and rewarding and they remind me why I chose medicine as a profession.

Claudia Fegan *Testimony* for US Senate Subcommittee on Primary Care and Aging. January 29, 2013.

Off the Hamster Wheel? Qualitative Evaluation of a Payment-Linked Patient-Centered Medical Home (PCMH) Pilot

ASAF BITTON,^{1,2} GREGORY R. SCHWARTZ,^{1,2}
ELIZABETH E. STEWART,³ DANIEL E.
HENDERSON,⁴ CAROL A. KEOHANE,¹ DAVID W.
BATES,^{1,2,5} AND GORDON D. SCHIFF^{1,2}

¹*Brigham and Women's Hospital;* ²*Harvard Medical School;* ³*American Academy of Family Physicians, National Research Network;* ⁴*Columbia University Medical Center;* ⁵*Harvard School of Public Health*

Context: Many primary care practices are moving toward the patient-centered medical home (PCMH) model and increasingly are offering payment incentives linked to PCMH changes. Despite widespread acceptance of general PCMH concepts, there is still a pressing need to examine carefully and critically what

PCPs “Running out of fuel”

**WE WERE DYING ON THE TREADMILL,
TRYING TO RUN FASTER AND FASTER. I
FIGURED I COULD EITHER BECOME A
DERMATOLOGIST OR BUY A BOWLING
ALLEY**

Bitton, Schiff- Off the Hamster Wheel Milbank Quarterly 2012

The New York Times

The Widespread Problem of Doctor Burnout

By PAULINE W. CHEN, M.D.



Fuse/Getty Images

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The patient, a powerfully built middle-aged restaurant worker, had awakened one morning with a tight pain in his shoulders that traveled down his right arm. At work, he could barely shrug his shoulders or turn his head. “My fingers were so weak,” he recalled, “that I couldn’t even get a good grip around a glass of water.”

Physician Burnout

"Self-love, my liege, is not so vile a sin/As self-neglecting."

King Henry V, Act 2, scene 4

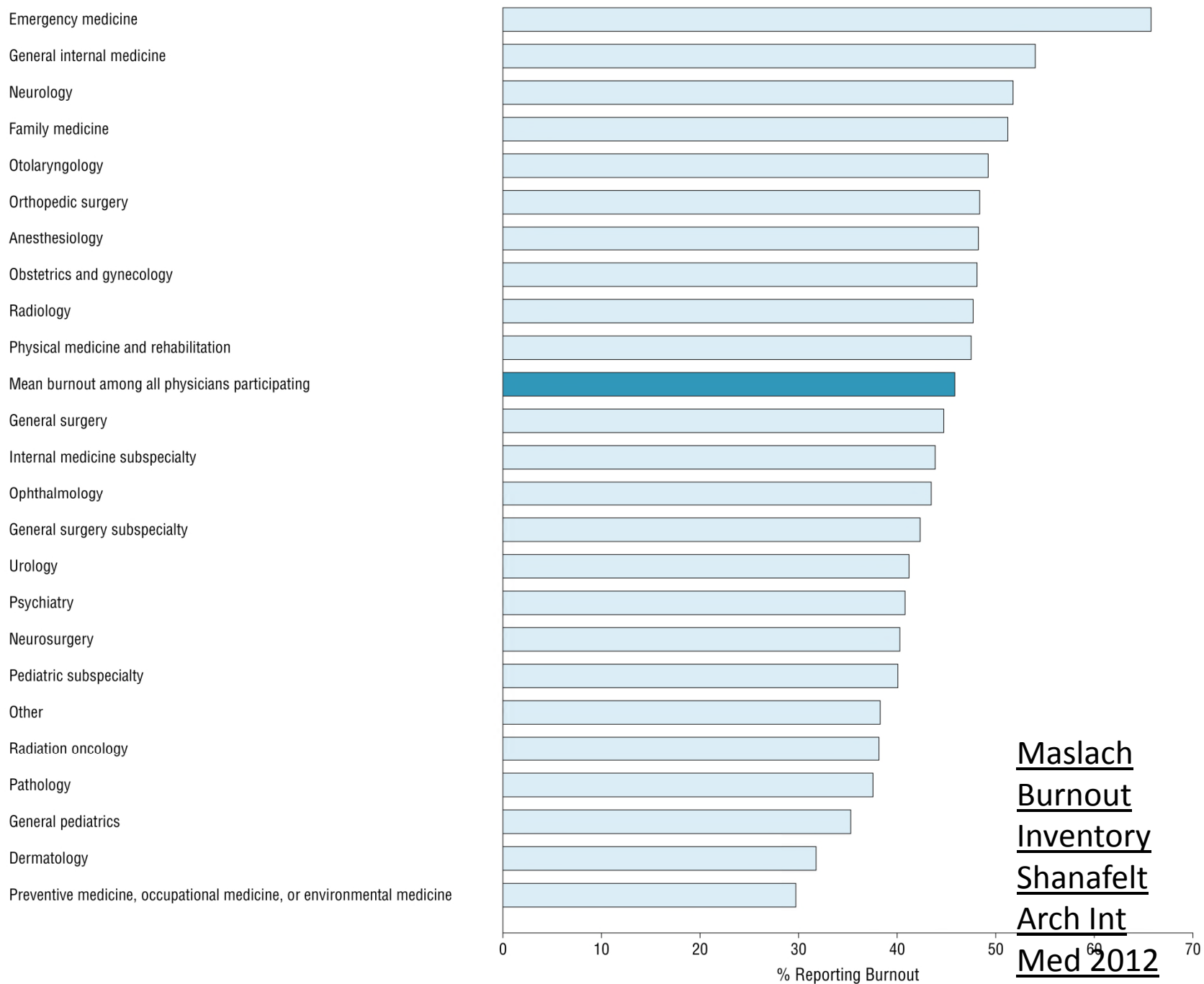
Physicians are often prone to burnout because of their personality profiles. "We want people who are driven, who are competitive, who can excel at everything that they do. What do they do when they get into practice? They try to do everything, and they have this complex which also says they must succeed at everything," commented T. Jock Murray, MD, director of the medical humanities program at Dalhousie University in Halifax, professor of medicine (nephrology), and director of the Dal-

cording to a recent study that examined graduates of the Johns Hopkins School of Medicine (*Arch Intern Med.* 2000;160:3209-14).

In his article "Physician Renewal: The Importance of Life Balance," Peter S. Moskowitz, MD, suggests that physicians deny their own emotions and needs as a survival mechanism. Because doctors are advised not to allow themselves to feel too much sympathy or sadness, some physicians may shut down emotionally (*Sonoma Medical Magazine*, 1999;50. Available

occurring in medicine are particularly difficult for those who became physicians in order to attain power or control in some way. In fact, a study published in *Western Journal of Medicine* found a correlation between burnout and a perception of loss of control. As perceived control, social supports, and resources increased, burnout decreased. The study concluded that lack of perceived control was the best predictor of burnout (*West J Med.* 2001;174:13-8).

Another article in the same issue of



Maslach
Burnout
Inventory
Shanafelt
Arch Int
Med 2012



RICHARD GUNDERMAN - Richard Gunderman, MD, PhD, is professor of radiology, pediatrics, medical education, philosophy, liberal arts, and philanthropy, and vice-chair of the Radiology Department, at Indiana University. His [most recent book](#) is *X-Ray Vision*.

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The Root of Physician Burnout

AUG 27 2012, 9:47 AM ET 41

Incentivizing with money is a self-fulfilling prophecy of cynicism. We must promote compassion, courage, and wisdom among our physicians before we "make a sordid business of this high and sacred calling."



Sir William Osler (Sam Blackman/Flickr)

A colleague of mine in primary care medicine has decided to leave the practice of medicine. She is very well trained, has impeccable professional credentials, and works in a thriving practice. Over the past several years, however, she has noticed an unrelenting decline in the sense of fulfillment she derives from her work. She feels increasingly frustrated with what she calls the "bureaucratization" of medicine, and resents spending "more time

-*while reducing* dissatisfiers (hassles, bureaucracy, pay cuts, clunky IT systems) is an important part of addressing burnout, it's only half of the equation.
- ... the key [to combating physician burnout] is promoting professional wholeness, which flows from a full understanding of the real sources of fulfillment

- While useful in some respects, the stress-reduction approach addresses only the less important of the two sides of the problem. Reducing stressors in the work environment may offer real benefit... It is like providing symptomatic relief to a patient without ever addressing the underlying disorder or encouraging the development of life habits that foster a positive state of well-being. Instead of merely reducing the bad in medical practice, we need to enhance the good

- William Osler, perhaps the most admired physician in American history, understood well the recipe for demoralization and burnout: "The path is plain before you: always seek your own interests, make of a high and sacred calling a sordid business, and regard your fellow creatures as so many tools of the trade."

- Being a professional means above all professing something, declaring openly in work and life that we stand for something beyond our own narrow self-interest. The more we treat physicians as though they were self-interested money grubbers, the more we de-professionalize them. And a de-professionalized physician is inevitably a demoralized and burnt-out one.



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What do Clinicians Derive from Partnering with their Patients?: A Reliable and Valid Measure of “Personal Meaning in Patient Care”

Gail Geller^{1,2,3,4}, Barbara A. Bernhardt⁵, Joseph Carrese^{1,2}, Cynda H. Rushton^{1,4,6}, and Ken Kolodner⁷

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Abstract

Burnout Less from Partnering with Patients:

Validation Personal Meaning Scale

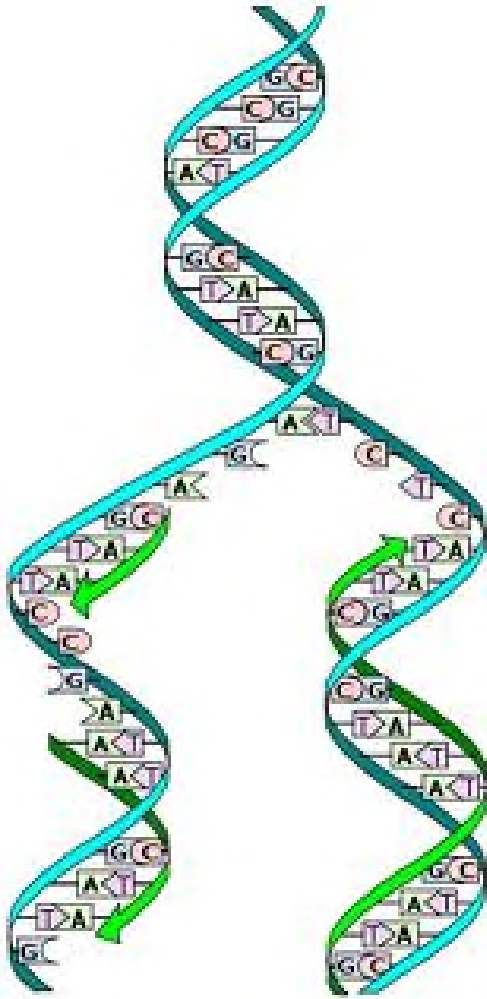
Table 4

Predictive validity: relationship of meaning with burnout, gratitude and satisfaction scales as characteristics

	Pearson correlations with Meaning	
	r	p
Burnout		
Overall	−.31	<.001
Emotional Exhaustion	−.13	=.067
Depersonalization	−.29	<.001
Professional Accomplishment	−.44	<.001
Gratitude	.34	<.001
Professional Satisfaction	.16	=.022
Years in Practice	.19	=.006

- ...the secret of the care of the patient is in caring for the patient”
 - Francis W. Peabody 1925 The Care of the Patient
- ...The secret for loving medicine is loving the patients

Two strands intertwined DNA



- Collective advocacy for social change
- Personal advocacy helping individual patients

Conclusions

1) Profession-patient boundaries

- An issue permeating clinical care
- Important subject for reflection, caution, education, contention, re-evaluation and research

2) Maintaining strict sexual boundaries

- An inviolable necessity
- A paradigm that *ought not* mandate unbalanced, blanket proscriptions on all personal relationships

Conclusions

- 3) Like all medicine need weigh benefit and risks, individual and broader contexts.
- 4) Caring for and about patients, establishing meaningful human relationships is at heart of healing *plus* our own professional satisfaction
- 5) Students, residents, we all need help grappling with boundary issues
 - Thus need for openness, experience, case discussions, and input from patients.
 - Need training; can't jump in, do heart transplant

Conclusions

- 6) Disparities – not abstract statistics but realities part of every clinical encounter.
 - Poverty, injustice, social determinants of health can neither be ignored, nor individually cured but we can make a difference exercising solidarity, compassion, and using our resources to help.

Research Questions

1. What is prevalence various types of caring acts, problems
 - Frequency; incidence problematic outcomes
2. What are various professionals' views on:
 - Whether appropriate in selected situations
 - Experiences (+ and/or -); lessons for optimizing
 - How vary by profession, demographic, geographic
3. Patients'/public's views
4. Risk factors for more negative outcomes
 - Can these be anticipated, minimized, mitigated
5. How to support, optimize positive potentials
6. Wealth/income gap between MD's & patients
 - How has changed; how has changed relationships; implications

UNUSED SLIDES



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Solidarity

From Wikipedia, the free encyclopedia

- **Solidarity** is the integration, and degree and type of integration, shown by a society or group with people and their neighbors.[1] It refers to the [ties in a society](#) that bind people to one another.

Charity or Solidarity

- International solidarity is "not an act of charity but an act of unity between allies fighting on different terrains toward the same objectives." - Samora Machel
- "Unlike solidarity, which is horizontal and takes place between equals, charity is top-down, humiliating those who receive it and never challenging the implicit power relations." - Eduardo Galeano]

- "Solidarity is not a matter of altruism. Solidarity comes from the inability to tolerate the affront to our own integrity of passive or active collaboration in the oppression of others, and from the deep recognition of our most expansive self-interest. From the recognition that, like it or not, our liberation is bound up with that of every other being on the planet, and that politically, spiritually, in our heart of hearts we know anything else is unaffordable." - Aurora Levins Morales

- "Solidarity does not assume that our struggles are the same struggles, or that our pain is the same pain, or that our hope is for the same future. Solidarity involves commitment, and work, as well as the recognition that even if we do not have the same feelings, or the same lives, or the same bodies, we do live on common ground." - Sarah Ahmed

- "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together."
- Lilla Watson Australian Aboriginal activist speaking to social workers 1985*

*"not comfortable being credited for something that had been born of a collective process" and prefers that it be credited to "Aboriginal activists group, Queensland, 1970s"

Mon rock
Heaven on
Earth!



Otherwise
for the better

A Celebration of
Damon L. Walker
Going Home to Paradise

for the
better

deepen our
relationship

Entered Earth
March 10, 1936

Returned to Paradise
November 16, 2011



Chicco Adams

Date of Service: November 28, 2011

Time of Service: 6:00pm to 7:00pm

Place of Service: 654 Cummins Highway


Mattapan, Ma, 02126

Officiating Minister: Rev. Marilyn C. Williams

Pride

Heaven and
Earth

JFK Library launches 'Moon Shot' exhibit

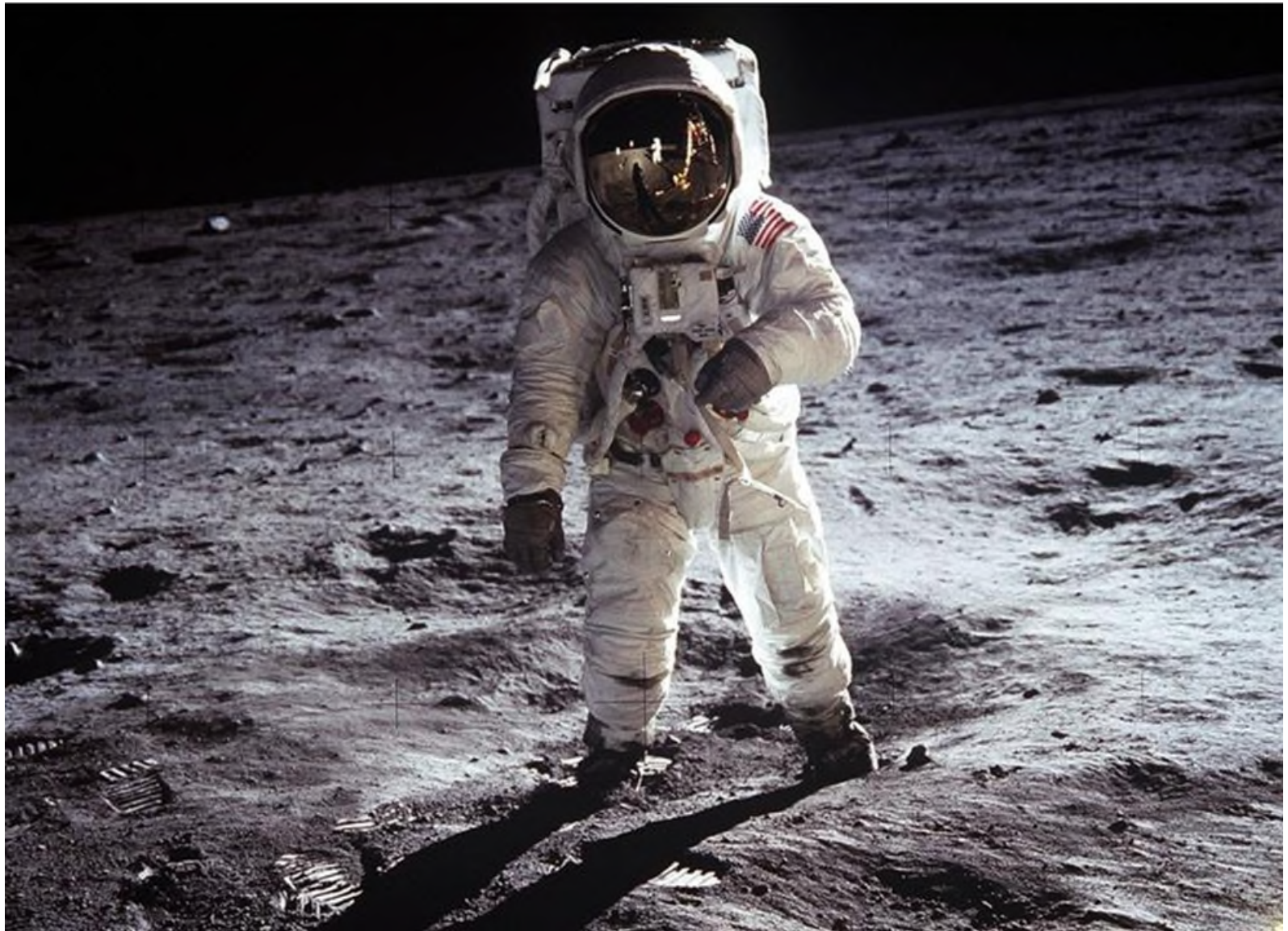
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JFK Library launches 'Moon Shot' exhibit

« Previous Next » 🔍 2







This section **is a candidate to be copied to Wikiquote using the Transwiki process.**

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Perspective

Shared Decision Making — The Pinnacle of Patient-Centered Care

Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A.

N Engl J Med 2012; 366:780-781 | [March 1, 2012](#)

- Shared decisionmaking or
Solidarity-based caring and joint advocacy
- Clarifying patients' options
 Technical role in explaining choices
 Good for its emphasis on involving pt.
- Vs. actively helping, advocating, expanding options
- Standing on sidelines vs. being on patients' side
- Consumer choices vs. emphasis on meeting pts
needs
- Removing ourselves from what patients are
experiencing.

**"Cowardice asks the question, 'Is it safe?'
Expediency asks the question, 'Is it politic?'
But conscience asks the question, 'Is it right?'
And there comes a time when one
must take a position that is
neither safe, nor politic, nor popular
but because conscience tells one it is right."**



· Dr. Martin Luther King, Jr.



- Maybe next conference will start w/ how to minimize, mitigate, and overcome some of the negatives and risks, rather than the need to shut the door on helping patients to fullest extent possible.
- True risks of tokenism, burnout, disappointment, efforts overridden
- Not reasons not to help patients but reasons to work harder/better to try to figure out how to better help to overcome these risks and barriers,

- There are so many ways you can help a patient as a doctor, why do you have to resort to that?
- We are admonishing you for your own good, to protect you against potential negative consequences
- Your remind me of a bumper sticker from the 60's "Practice Random Acts of Kindness"—that is a fine philosophy but it has no place in the doctor-patient relationship (actually Anne Herbert 1982)

Andrew G. Wallace, MD

Educating Tomorrow's Doctors: The Thing That Really Matters Is That We Care

ABSTRACT

The unique purpose of medical schools is to select and educate competent, caring physicians capable of meeting society's expectations for health care. The author discusses this purpose first in the context of liberal education, which provides a broad perspective essential in the education of doctors and other professionals. Such an education can be achieved partly by how medical students are selected and by effectively uniting it with professional learning. The most important goal of liberal education is to promote intellectual wholeness as a lifelong pursuit of physicians.

Second, the author reviews medical curricula, which have been slowly evolving away from a focus on providing instruction and toward one of producing learning. This new approach is a more rational one, and can be seen in some schools' reductions of lectures and increases in team teaching and problem-based learning, and earlier exposure of students to patients, especially in ambulatory

care settings. An important role of medical educators is to provide enough free time for students to learn, and to pay attention to the "informal curriculum," where the unwritten ethical codes of medicine are revealed.

The author then turns to issues of professionalism, especially that elusive part that goes beyond expertise. He emphasizes that the training of tomorrow's doctors is ultimately a public goal, and that medical schools must help restore public trust in doctors by selecting and nurturing professionals who see medicine in a broad social context. He reiterates that a liberally educated doctor is most likely to have such an outlook, and concludes by urging medical educators to remember that there is no substitute for a doctor's competence, caring, and professionalism expressed in the context of a liberally educated mind. And that the most important thing that educators can do as they bend to their task is to care.

Acad. Med. 1997;72:253-258.

Quotes from other Health Professionals

- Hospital security guard commenting on issue of boundaries and helping patients

***THESE PEOPLE DON'T UNDERSTAND
WHAT LIFE IS LIKE OUT THERE***