PATIENT-PHYSICIAN RELATIONSHIPS:

AN EXAMINATION OF PHYSICIAN PERSPECTIVES

IN STORIES FOR COLLEAGUES

A dissertation submitted to the Caspersen School of Graduate Studies

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ABSTRACT

Patient-Physician Relationships:
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Doctor of Medical Humanities Dissertation by

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A unique collection of non-clinical writing by physicians resides in a column called "A Piece of My Mind," (APOMM) found in the weekly *Journal of the American Medical Association* (*JAMA*). The columns are informal narratives, primarily written by physicians and medical students about training, practice, patients and personal thought. The purpose of this dissertation is to analyze select APOMM columns about patient-physician relationships, published regularly by the physician-writers and editors of *JAMA*.

All of the columns published from May 1980 through April 2016 (totaling 1,438) were read, categorized and analyzed. Five broad themes emerged as follows: stories about patients, stories about medical practice, stories related to the medical humanities, personal stories, and stories about dying and death.

Stories about patient-physician relationships regularly appear in all five categories over the publication period. The thesis of this work is two-fold: first, that the columns are consistent examples of the humanities applied to medical practice, each column informed by the author's personal and professional perspective; and second, that the columns as a collection are a casual primer in the medical humanities, in stories with a wide range of physician interpretation about factors that enhance or detract from an understanding of

patients. Columns cited include topics showing the breadth of physician writing on patient-physician relationships.

While medicine has changed greatly since the inception of APOMM, the columns remain consistent examples of physician investment in relationships with patients as the art of medicine, and a cornerstone of practice. Doctors discern relationships with patients through individual lenses, colored by life experience and professional experience including philosophy, ethics, faith, sociology and the arts as elements of the humanities. As such, their APOMM columns about giving and receiving care are both individual and collective works about the humanities in the practice of medicine, the importance of understanding patients and the delicate dynamic of the patient-physician relationship.

To Dr. Dee
in lasting, loving memory

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INTRODUCTION

This dissertation is a description and analysis of columns from a unique collection of non-clinical physician writing, found in the "A Piece of My Mind" (APOMM) feature of the weekly *Journal of the American Medical Association* (*JAMA*). The columns are personal narratives primarily written by physicians and medical students about medicine, including training and practice, professional mentors, patients and personal matters involving reaction to illness and loss.

Columns about patient-physician relationships in particular are the subject of this dissertation, appearing consistently over the thirty-six year publication period of *JAMA* examined for this work. The thesis is a twofold argument about the columns. First, they are regularly occurring examples of the humanities applied to medical practice; each column is informed by the author's personal and professional perspective, including individual philosophy, ethics, psychology and sociology. Second, the columns as a collection therefore, are a casual primer in the medical humanities, told in stories providing readers with a wide range of physician interpretation of factors that enhance and detract from their understanding of, and professional relationships with, patients.

Each physician author of APOMM chooses to enlighten colleagues after experiencing a particularly memorable patient encounter, whether positive or negative. Of such interactions, Gillie Bolton, in an article about the medical humanities applicable to this dissertation, writes, "Medical and healthcare practice, education and research primarily concern individual people, each of whom, made up of inextricably linked psychological, emotional, spiritual and physical elements, is also inevitably impinged

upon by cultural and social forces."[1] The factors Bolton describes pertain to the humanities, and in patient-physician interactions they relate to the practice of medicine. Consequently the APOMM stories are informal examples of the humanities applied to medicine in stories about patients, rather than more formal academic writing about the concept of the medical humanities.

The columns are described in five chapters focusing on three factors that influence patient-physician relationships: specific human attributes and behaviors that enhance or detract from patient-physician encounters, electronic data gathering and management in medical care, and physician experiences as patients. Although these three factors may initially seem disparate, this dissertation shows how they affect patient-physician communication and interaction in positive and negative ways, contributing to greater writer and reader understanding of the patient role, and the patient-physician relationship.

The primacy of patient-physician relationships in medicine is a theme unchanging over time in the columns analyzed here, despite influences on medical practice. Although the APOMM columns sometimes reference changing factors affecting caregiving (technologic advances in diagnosis and treatment, changes in healthcare delivery procedures and policy, social issues affecting medicine), the writers regularly focus on the importance of establishing professional relationships with patients. The APOMM columns are familiar lessons in medicine from physician-writers in a range of treatment settings and circumstances. The authors tell stories about how they understand patients, and the significance of the patient-physician relationship in their professional lives.

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[1] Gillie Bolton, "Boundaries of Humanities: Writing Medical Humanities," *Arts & Humanities in Higher Education* 7, no. 2 (2008): 132.

A Piece of My Mind

The May 9, 1980 issue of *JAMA* contained an invitation to readers to submit writing for publication in a new feature of the journal called "A Piece of My Mind." The title of the invitation, however, was "For the Peace of Your Mind," and follows in full:

> We hasten to assure our readers that A PIECE OF MY MIND (see p 1846) is not intended as a sounding board for peevish gripes, nit-picking beefs, or sundry assortments of righteous indignation, which are usually prefaced by an angry "let me give you a piece of my mind." Nor is this section of THE JOURNAL meant to be a podium for pompous preachments and ex cathedra pronouncements. Nor again is it designed to be a forum for half-baked speculations and warmed-over hypotheses. Least of all is A PIECE OF MY MIND envisaged as a jamboree of jokes and a shivaree of limericks.
>
> What we have in mind for the newly inaugurated feature is not a formal court of opinion but an informal courtyard of creativity, in which physicians display vignettes of their nonscientific and not strictly clinical observations, experiences, reflections, and fantasies tinged with philosophy or humor.
>
> The appearance of A PIECE OF MY MIND will, of necessity, be determined by available contributions. These will not be assessed by peer review. They will be accepted or rejected without explanation. Based on the principle of "De gustibus non est distutandum," this arbitrariness needs no apology. Do take a chance and mail us your masterpieces.[2]

This invitation to the physician readership of *JAMA* to share their thoughts set in motion a writing tradition that continues today.

The editor-author of the invitation, Dr. Samuel Vaisrub, laid the ground rules for aspiring physician authors. His informal approach reflected the intent to capture less scientific, less clinical writing by physicians than was usually found in professional medical journals. Roxanne Young has edited APOMM since 1984 (four years after inauguration), and currently serves as Associate Senior Editor at *JAMA*. Young provided background information on the inception of APOMM, credited to Dr. Larry Grouse, who was a *JAMA* senior editor at the time (Roxanne K. Young, January 28, 2013, e-mail

[2] Samuel Vaisrub, "For the Peace of Your Mind," *JAMA* 243, no. 18 (May 9, 1980): 1845.

message to author). Although Young could not shed light on the choice of title for the column, she recounted that Dr. Grouse wanted a title that would signal the non-clinical nature of the writing (Roxanne K. Young, January 28, 2013, e-mail message to author).

The choice of title for the invitation to contribute to the APOMM column is more than a play on words. "For the Peace of Your Mind" suggests relief will come to authors who choose to write for their physician colleagues. Although the title chosen for the column, "A Piece of My Mind," implies the reader should prepare for a diatribe from the author (ostensibly for the reader's betterment or benefit), the title chosen for the introduction to the column suggests instead that it is the writers who will benefit, by obtaining peace of mind from telling their stories. Whether the authors achieve such peace is a private matter. The APOMM title remains today, and prepares the reader for personal writer opinion, rather than scientific analyses or findings.

The authors of APOMM are referred to in this dissertation as physician-writers. Physician-writers are either: trained but non-practicing physicians, practicing physicians, retired physicians, or students (medical students, residents, fellows) working in non-fiction, fiction or poetry, and published in professional or lay venues. The majority of APOMM writing comes from practicing physicians writing in non-fiction prose. The column did not appear in every issue in the early years of publication, but appears in virtually every issue of *JAMA* at present.

Stories come from women and men studying to become doctors, and doctors in practice, in research and in education, representing a variety of specialties and a broad range of age and clinical experience. Not all authors reveal their medical specialties in their writing, but those who do span general medicine and surgery, and specialty care.

Many of the authors work in varied settings (teaching hospitals, community hospitals, outpatient treatment centers, academic positions, research activities) in the United States when they write their columns; a small number of authors recount stories from international health care settings and military environments. The authors often write several years later about events that took place either during their medical training or while in practice. Some authors reflect on their careers as they approach, or are in retirement. The stories examined here, regardless of author, practice type, practice setting and timing, often focus on relationships with patients at the heart of clinical medicine.

The literary form and authorship of the APOMM columns has changed over time. Some submissions in the first years were short poems and short prose pieces. Longer columns began to appear in the 1990s, and poetry appears as a separate feature of *JAMA*. In the introduction to a collection of APOMM columns published by the American Medical Association (AMA) in 2000, editor Roxanne Young described other changes:

> Not surprisingly, during the column's early years, most of the physician-authors were men, but recently, authorship seems equally distributed between the sexes – and most likely among ethnic groups, no doubt reflecting the current demographics of medical school admissions. They represent every conceivable medical specialty, and every medical walk of life.[3]

Insofar as author gender, ethnicity and medical specialty can be ascertained from the APOMM columns, the same diversity appears in columns published since the AMA compilation in 2000.

The APOMM columns are unlike professional, clinical writing by doctors. In daily practice, doctors record their findings and impressions about patients, both in outpatient and inpatient settings. Members of the healthcare team make contributions to these clinical records as well. The information guides the team in establishing diagnoses,

[3] Roxanne K. Young, ed., *A Piece of My Mind* (Chicago: AMA Press, 2000), xv.

plotting courses of action, implementing the plan of care, monitoring patient response and following the patient's course.

On the other hand, the APOMM columns are most often the product of single authorship, written for physician colleagues rather than others on the healthcare team, as in a clinical setting. The writing style is not professional or scientific. The contributors sometimes express basic human emotion, as when Dr. John Frey, in recounting an experience from his first medical rotation involving a ninety-eight year old patient recalls, "I remember thinking that I had never seen and certainly never touched anyone that old."[4] At the other extreme, some authors write about the emotional effects of profoundly complicated treatment situations, as when Dr. Thomas Smith details his difficulty in deciding how to advise a patient with metastatic cancer for whom an autologous bone marrow transplant might bring limited chance at survival, weighing his academic, administrative, financial, legal and ethical responsibilities.[5] The authors share triumphs and travails from training and practice. They deal with loss inherent in their profession including the deaths of patients and colleagues, and their own illness experiences. Each individual author writes to colleagues about experiences and challenges in medicine.

The language APOMM writers use is typically straightforward, with rare literary embellishment. The clinical details and medical terms in the stories usually are limited, establishing the setting for the reader but not assuming the central focus. The doctors tell practical stories about what they see, what they do, and (overtly or subtly) how they feel. In the stories that are the focus of this dissertation, they remind each other about the

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[4] John J. Frey III, A Piece of My Mind, "Ward 55," *JAMA* 282, no. 20 (November 24, 1999): 1897.

[5] Thomas J. Smith, A Piece of My Mind, "Which Hat Do I Wear?," *JAMA* 270, no. 14 (October 13, 1993): 1657-59.

importance of understanding patients, and preserving the patient-physician relationship in an increasingly complicated and technologic clinical environment.

Thirty-seven years after Dr. Vaisrub's opening invitation to aspiring authors, the current "Instructions For Authors" on the *JAMA* website describe APOMM as "Personal vignettes (eg, exploring the dynamics of the patient-physician relationship) taken from wide-ranging experiences in medicine; occasional pieces express views and opinions on the myriad issues that affect the profession."[6] This is a brief, general and more formal description of the variety of writing in APOMM as compared to the initial invitation from 1980. Although not originally required, peer review later became part of the approval process (Roxanne K. Young, January 28, 2013, e-mail message to author). The word limit for submissions currently is 1600 words.[7] *JAMA* receives approximately five hundred to six hundred submissions to APOMM per year, with a publication rate of approximately ten percent (Roxanne K. Young, January 28, 2013, e-mail message to author). *JAMA* is available to American Medical Association members and other readers, and "is the most widely circulated medical journal in the world, with more than 320,000 recipients of the print journal, 1.2 million recipients of electronic tables of contents and alerts, and over 16 million annual visits to the journal's website."[8]

Every week, the authors write missives in the form of APOMM columns. They tell stories about how they practice, often via their interactions with patients. The columns are personal, intimate and regular within the realm of non-clinical physician

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[6] "Instructions for Authors," *Journal of the American Medical Association*, accessed February 12, 2017, http://jama.jamanetwork.com/journals/jama/pages/instruction-for-authors.

[7] Ibid.

[8] "About *JAMA*," American Medical Association, accessed February 12, 2017, http://jama.jamanetwork.com/journals/jama/pages/for-authors#fa-about.

writing. *JAMA* dispenses the APOMM column to the readership each week, almost as a therapeutic product from a pharmacy. According to editor Roxanne Young, readers seek out the column, inquiring of the editorial staff when it does not appear (Roxanne K. Young, January 28, 2013, e-mail message to author). The consistent reader interest in the personal vignettes of APOMM is a testament to the regularity and longevity of the column.

William Brendel observed of storytelling, "Narratives may point out what we have come to admire in ourselves as well as things we wish to change in a substantive fashion. In this sense, narratives present a powerful means for creating possible selves."[9] Thus physician-writers sharing thoughts and aspirations about careers in medicine provide a guide for readers about what insightful medical practice involves. Each story in APOMM is a puzzle piece about life in medicine; taken together, they reflect the richness of caring for fellow human beings and the range of human emotion witnessed and experienced by doctors.

The columns about patient-physician relationships sometimes involve changes in the author's understanding or approach to care: transformation of the physician's knowledge and opinion from a patient encounter; accommodation to changes in medicine (for example, consistent complaints about the business model imposed on medicine); and transformation of self (in stories about their personal illnesses). While such change is expected over time, the stories regularly focus on understanding and preserving the patient-physician relationship, no matter the nature of transformation in medicine.

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[9] William Brendel, "A Framework for Narrative-Driven Transformative Learning in Medicine," *Journal of Transformative Education* 7, no. 1 (January 2009): 34.

APOMM exists because of patients and doctors. Patients are the reason most people train for careers in medicine. Patients rely on the skills of physicians: people with whom they have a range of relationship, to whom they surrender their bodies and in whom they place their trust and faith. Physician-writers open a door for readers to learn about experiences in caring for patients. Many APOMM authors write about caregiving moments with patients, and the way such experiences inform their professional, and sometimes personal lives.

Methodology

The APOMM columns published from May 1980 through April 2016 total 1,438; all columns were read for this work. The column is still published, but April 2016 was chosen as the cut-off date to include thirty-six complete years of columns. Over this period, hundreds of physicians shared their thoughts and opinions on patients, practice and understanding in medicine; approximately 200 contributed more than once. A small number of non-physician authors (approximately 165) also wrote in APOMM. They included nurses, social workers, clergy, doctorally-prepared authors, family members of patients, children and grandchildren of physicians. Much of the non-physician writing contained perceptive observations about the medical profession, based on personal experiences, however the columns of non-physician contributors were not included in this dissertation.

Select early years of APOMM columns (over varying periods of time depending on the institution), exist in hard copy, in medical and some community libraries retaining issues of *JAMA*. Readers can access later columns electronically. In addition to the

columns, the American Medical Association published two collections of select APOMM columns, one in 1988 (containing eighty columns) and one in 2000 (containing one hundred columns). The Forewords and Introductions include broad descriptions of the selected columns by *JAMA* editors. In the Foreword to the collection published in 2000, Kathryn Montgomery explained,

> These "Pieces," . . . are about the moments that survive the trip home, the enforced distance, the suppression of emotion. They are about the many reasons physicians are devoted to their work. They give us not just the wisdom that accrues to the experienced physician but accounts of how hard and painful it can be to acquire that wisdom. Together they offer the hidden curriculum of clinical practice: the ways people meet death, the uses of a physician's emotions, the ways of surviving, the rewards of a life in medicine.[10]

In the seventeen years since publication of the 2000 collection, personal accounts of medical practice by physicians have increased in periodical and book form, and some doctors now write blogs about their professional experiences. Montgomery wrote of APOMM: "Now widely imitated in other medical and public health journals, these insiders' accounts of medical practice constitute a secret history of what it has been like to take care of the ill (or in some stories to *be* ill) at the end of the 20th century."[11] The APOMM collection is a broad, deep repository of stories from practice, in weekly installments for physician and student readers.

The methodology for this project began with gathering the APOMM columns and reading them in chronologic order. A spreadsheet was created to list author, year, volume and number of the issue for each column. A single line summary of the column was also

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[10] Kathryn Montgomery, Foreword, *A Piece of My Mind*, ed. Roxanne K.Young (Chicago: AMA Press, 2000), xiv.

[11] Ibid., xi.

recorded. Various filters then were used to identify key words, themes, subjects and writer tones.

Conceptual organization of the columns occurred as reading progressed. The theoretical framework of *grounded theory* was applied loosely to interpret and categorize the columns. This theory was developed by Barney G. Glaser and Anselm L. Strauss, and published in their 1967 book *The Discovery of Grounded Theory: strategies for qualitative research*.[12] Glaser and Strauss describe the concept of grounded theory as deriving theory from data. The key feature of their theory is the use of the constant comparative method of qualitative analysis.[13] This method involves analyzing and organizing data simultaneously by constantly comparing individual data points, identifying similarities and differences, and establishing a classification of the data.[14] The analysis forms the basis for developing a theory about the data applicable to all of the data in a general way. Grounded theory is intended for application to large data sets gathered in sociologic study settings. The APOMM columns do not constitute such data in that they are not direct observations of human behavior; however in their written form, they are personal reflections about human behavior from physicians caring for patients.

The constant comparative analysis method was used as a guide in reading the APOMM columns; each column was considered an individual data point, and each column was classified into one of five categories that emerged as reading progressed.

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[12] Barney G. Glaser and Anselm L. Strauss, *The Discovery of Grounded Theory: strategies for qualitative research* (New Brunswick [USA]: Aldine Transaction, 1967).

[13] Ibid., 101.

[14] Ibid., 43.

Classification involved careful reading of columns with comparison to the others; similarities, differences and trends were noted.

Although no formal theories were derived from the use of constant comparative analysis in this project, the method was used to organize the large volume of writing, make observations about subject and style of the writers, and draw conclusions about the writing on patient-physician relationships. Five broad categories of stories were identified as more and more columns were read: 1. patients as the subject (stories about the writer's experience with a particular patient), totaling 233 columns, 2. medical profession (including observations, criticisms, and recommendations about medical practice), totaling 481 columns, 3. medical humanities (columns about bioethics and other humanities subjects applied to medicine, such as philosophy, psychology, sociology and the fine arts), totaling 225 columns, 4. personal accounts (authors' experiences as patients, with their family members as patients, and expressions of personal thought and opinion not pertaining to the other themes), totaling 390 columns, and 5. dying and death (regarding patients, family members, colleagues [including physician suicide], friends, and authors facing their own deaths), totaling 109 columns.

Glaser and Strauss advised that each "incident," (in this project each APOMM column), be classified once, "for the most important among the many properties of diverse categories that it indicates."[15] This technique occasionally proved challenging when certain APOMM columns could have been classified in more than one way, especially those about dying and death, which often involved observations about the

[15] Barney G. Glaser and Anselm L. Strauss, *The Discovery of Grounded Theory: strategies for qualitative research* (New Brunswick [USA]: Aldine Transaction, 1967), 108.

medical profession, the medical humanities, and sometimes were personal as well. In such cases, effort was made to choose a category based on the main theme of the column.

Within the five categories, additional subset topics appeared, involving what were eventually considered factors that enhance, or detract from relationships with patients. Examples of enhancements include stories about learning from, and listening to patients. Examples of factors potentially diminishing patient-physician relationships are socioeconomics, race and business influences in medicine. These columns are the subjects of later chapters.

The original goal of this project was to describe and analyze the whole of the APOMM collection from May 1980 through April 2016. That goal proved too broad, especially as columns about patient-physician relationships were identified in all of the five initial categories used to group them, over the entire publication period. The focus of this dissertation became features of the patient-physician relationship told in stories from APOMM physician-writers, as consistent examples of the humanities in medicine.

Critical reading was aimed at identifying patterns in writing style (either qualitative changes such as increases in positive or negative tones, or quantitative changes such as an increase in columns on a particular topic), the use of specific language/vocabulary or other noticeable changes in writing. Such variations over time generally were not discernable, although select columns referenced changes in medical practice and social changes influencing medicine. For example, several writers who were young practitioners when patients were first seen and diagnosed with HIV/AIDS in the early 1980s reflected, many years later, on that experience and how care and patient survival had changed. Similarly, some authors noted advances in diagnostic and

treatment technology, but often as incidental parts of larger stories consistently pertaining to experiences with patients.

While medical practice has changed tremendously since the inception of APOMM, physician-writers continue to tell about those aspects of medicine that are more interpersonal than scientific. Although some of the early authors likely would not recognize the medical landscape in which their colleagues work today, their observations and personal stories from the early years of the column are very similar in tone and focus to those written in later years, centering on the importance of understanding patients to establish therapeutic relationships.

* * *

The first chapter considers the APOMM columns within the context of medical education trends in the twentieth century, and within the context of similar non-clinical physician writing. Chapter Two is about qualities that enhance patient-physician relationships, while Chapter Three is about factors that diminish patient-physician relationships. Chapter Four focuses on electronic data gathering and management (particularly the electronic medical record), as a transforming influence on patient and physician storytelling and relationship, and Chapter Five is about the effect of illness on physicians' understanding of patient-physician relationships after they become patients. This work concludes with thoughts on the educational value of select APOMM columns, with observations about their importance, and their usefulness as individual and collective examples of the medical humanities in practice.

CHAPTER ONE

NON-CLINICAL STORYTELLING BY PHYSICIANS

This chapter has three purposes: 1. to address the idea of non-clinical storytelling by physicians in APOMM, and similar venues in professional medical journals, 2. to describe select publications about medical education that pre-date the start of the APOMM columns, 3. to discuss trends in medical education related to the medical humanities that coincide with, and follow, the inauguration of APOMM. The goal of this chapter is to set the APOMM columns into the context of medical education changes between the early 1900s to present, and to introduce the reader to the concept of non-clinical physician storytelling.

Physician Storytelling, and the Stories in APOMM

The APOMM authors write informally (albeit in *JAMA*, a professional journal) for their fellow medical practitioners, telling stories about their patient encounters that include a broad range of related subjects (professional standards, philosophical approaches, spiritual beliefs, political opinions, social causes). In this storytelling venue physician authors write about various aspects of careers in medicine each week. While some columns involve topical issues in medicine over the thirty-seven year-to-date publication of APOMM, the fundamental theme of many columns remains consistent, involving relationships: the authors write about relationships with patients, with their colleagues, with members of their communities and with their own families.

This dissertation explores doctors' understanding of the patient-physician relationship, and factors that enhance or diminish their encounters with patients. A

particularly unique perspective comes from doctors writing following personal illness, sharing their revelations about the patient role, and their changed understanding of relationships between patients and physicians.

The APOMM stories are told specifically to other doctors. The readership is self-selected (to a certain extent) by the authors, who know that medical students and physicians are the primary readers of *JAMA*. This feature makes the APOMM columns particularly intentional, since the heart of each story is the message the physician authors impart to colleagues who inhabit their shared world of medicine.

Physician-writers in APOMM figuratively connect to physician readers who have similar training and experience, and speak the same professional language. Larry and Sandra Churchill (non-APOMM authors who have written about the study of literature and medicine) observe,

> Storytelling is one way persons cross the threshold from individual interpretation of the actions and events of their lives to make contact with a larger range of common experience.
>
> We are moved to tell stories because we assume connections between our own story and the common experiential story (social, political, mythic) in which *we* – as both teller and hearer – know ourselves. Telling stories is not merely, or even primarily, an individual feat of self-revelation. Because stories manifest *trust* in the possibility of making connections through the telling, they move persons to tell and retell to reestablish connections with the common experience of the human condition, however varied its particulars.[1]

The APOMM columns draw readers into what has happened to patients, physicians and in some cases the medical profession. The authors trust (as the Churchills describe above) their medical colleagues with their stories about patients, their thoughts about practice and their opinions about the profession, over and over again, almost every week.

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[1] Larry R. Churchill and Sandra W. Churchill, "Storytelling in Medical Arenas: The Art of Self-Determination," *Literature and Medicine* 1, (1982, Rev. ed. 1992): 75.

Storytelling is a deliberative and personal act. The author chooses the subject of the story, and the time and place to tell the story, until then a private experience. It is difficult if not impossible to know what prompts a physician (or any storyteller) to share a story. Many APOMM authors decide to tell stories years after the fact, recalling patients from medical school, residency and fellowship years, very early in their careers. The Churchills observe of storytelling in general: "Human beings understand their experiences in and through the telling and hearing of stories. Narration is the forward movement of description of actions and events that makes possible the backward action of self-understanding."[2] This point applies to APOMM authors, especially when they reflect on events from early in their medical education and practice many years later, suggesting not only that such experiences make long-lasting personal and professional impressions, but that they are understood in a way perhaps not possible at the time. Doctors, like all storytellers, choose their subjects and tones consciously or subconsciously. The physician-authors select the critical messages of their columns, often weaving them into stories about patients. Why they choose to write is personal, and unknowable to the reader.

Time provides distance from the event, allowing it to ripen in the mind of the about-to-be author who later decides to tell a particular story. Dr. John Frey, writing in 1999, shared a fond memory of a patient from medical school. He cared for a woman with a deep vein thrombosis who told stories about her late husband and how much they "had loved making love."[3] The patient explained that although she did not want to die,

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[2] Larry R. Churchill and Sandra W. Churchill, "Storytelling in Medical Arenas: The Art of Self-Determination," *Literature and Medicine* 1, (1982, Rev. ed. 1992): 74.

[3] John J. Frey III, A Piece of My Mind, "Ward 55," *JAMA* 282, no. 20 (November 24, 1999): 1898.

she looked forward to being with her husband in heaven. The doctor wrote: "She laughed and whispered conspiratorially that when I heard thunder I shouldn't think of it as thunder but rather as her and her old man making love in heaven, shaking the place up."[4] The patient died unexpectedly during her hospital admission. Dr. Frey chose to tell his secret, closing with: "And as the great rain clouds rise over the plains and the summer storms roll in, whenever I hear thunder, I smile. And until I wrote this, no one has ever known why."[5] The doctor shared a special patient memory with his colleagues, trusting they would appreciate the lightheartedness the patient shared with him. An unexpected moment between two people exemplifies the special patient-physician relationships possible in medicine; the patient told something of herself that had nothing to do with being a patient but with being a wife and her belief in a heavenly afterlife. Many years later, the doctor decided to reveal the patient's gift to his colleagues, expanding their understanding of patient-physician relationships. The distance of time changed the story from Dr. Frey's privately held memory to a shared experience.

The APOMM stories are retrospective, allowing authors to reflect on events they describe. Several physician sons write about their physician fathers, and especially about their skills in relating to patients. Dr. Timothy Wolter writes in 1993 about his physician father: "If perchance his diagnostic and therapeutic armamentarium were sometimes dated, he more than compensated by the depth of his experience over decades of practice and by his insights into the intricacies of the physician-patient relationship, the

[4] John J. Frey III, A Piece of My Mind, "Ward 55," *JAMA* 282, no. 20 (November 24, 1999): 1898.

[5] Ibid.

complexities of which will ever defy our advanced imaging technologies."[6] The column, written twenty-four years ago, includes the same reference to the importance of the patient-physician relationship (especially as an essential counterbalance to the use of technology in caring for patients), as columns written on this subject in later years. Dr. Wolter looks back fondly on his father's understanding of people as equally valuable to his clinical skills, a demonstration of the inseparable blending of art and science in medical practice (central to the medical humanities), seen as essential by many of the APOMM authors.

The APOMM stories span a range of sentiment. Some authors, for example, learn about patients as people, enhancing their perception of the patient-physician relationship; select columns are described in Chapter Two. Conversely, there are fewer stories about factors that diminish meaningful interactions with patients, in stories involving patient-physician relationships either difficult to establish, strained, or broken (several of these columns are examined in Chapter Three). Some of these relationship hurdles involve human behavior regarding, for example, race or errors in medical judgment. Other hurdles are organizational or institutional, such as data collection and the advent of the electronic medical record, and they are the subjects of several columns explored in Chapter Four. Columns by physicians who become patients include good and bad experiences, perhaps particularly instructive for fellow physicians, involving new insight about the patient role; several columns are described in Chapter Five. The scope of APOMM themes in physician stories comes from conscious or subconscious thought, and

[6] Timothy J. Wolter, A Piece of My Mind, "In the Footsteps," *JAMA* 269, no. 23 (June 16, 1993): 2947.

near or distant experience, conveying messages to readers about patient-physician relationships.

Physician-writers share stories about how they are affected by their relationships with patients in APOMM. Dr. John Frey recalls patients early in his career, from the later vantage point of years of clinical experience. He reflects on what he gained from his patients, and addresses his message about the effect of patient interactions especially to students. He writes, "I tell the new residents that people will change them forever in ways they will only begin to understand much later in their lives. The beginning of each new training year is another book, another series of stories, that becomes richer with time, tucked in among the routines of daily work."[7] Dr. Frey employs the self-reflection described by the Churchills. The doctor contemplates the influence of his patients on his career, sometimes long after his encounters with them.

The experience of engaging with sick people and their families to bring relief makes doctors special storytellers. By virtue of their enormous responsibility, the role of the physician-writer is different from that of other caregivers and lay writers. Physicians know things about the human mind and body that most people do not. The intimate acts of touching a patient's body, or listening to a patient's fears, are central to medicine. Dr. Kate Scannell (a non-APOMM physician author) writes, "As doctors, we are uniquely positioned to bear witness to birth, death, pain, suffering, and healing."[8] Such

[7] John J. Frey III, A Piece of My Mind, "Ward 55," *JAMA* 282, no. 20 (November 24, 1999): 1898.

[8] Kate Scannell, Medical Writings; Physician-Writers' Reflections On Their Work, "Writing For Our Lives; Physician Narratives and Medical Practice," *Annals of Internal Medicine* 137, no. 9 (November 5, 2002): 780.

extraordinary observation is the purview of a cardiac surgeon who shares his thoughts with his colleagues in APOMM. Dr. Daniel Waters writes in 1998,

> But to hold the living heart of another human being is among the rarest of privileges. Those so favored should never lose sight of the inherent mystery and wonder of the experience. When you hold the heart you can know its story. You can read, as if in Braille, the brittle threads of atherosclerosis. You can feel the heft of ventricular hypertrophy or the flaccid ennui of dilated cardiomyopathy. When you hold the heart you can know *almost* all of its secrets.[9]

Dr. Waters draws his readers in, sharing his awe of the human heart and what he feels it reveals about the patient. The column is about one doctor's distinct perception of a patient. This may not be a conventional description of relationship, but it is about patient-physician relationship nonetheless. Moments shared with patients are unlike any other human interaction, and the stories from physicians-writers in APOMM come from such experiences.

The patient-centered stories like those in APOMM demonstrate the special relationships that can develop between people seeking care and their caregivers, and form a storytelling chain; the storytelling patient is linked to the physician in the clinical encounter, and physician storytellers are linked to colleagues who read their non-clinical writing about patients. Dr. Danielle Ofri writes,

> We are part of these stories, as they are a part of us. No matter how efficient medicine becomes, no matter how computerized, automated, algorithmed, wireless, evidence based, or "QA'ed" it becomes, medicine will always boil down to one caregiver with one patient, in one room with one story. This can be both the passion and the peril of medicine.[10]

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[9] Daniel J. Waters, A Piece of My Mind, "Holding the Heart," *JAMA* 279, no. 19 (May 20, 1998): 1520.

[10] Danielle Ofri, "The Passion and the Peril: Storytelling in Medicine," *Academic Medicine* 90, no. 8 (August 2015): 1006.

Publications Preceding the Start of Storytelling in APOMM

Several publications in the twentieth century influencing medical training (and consequently medical practice later) in the United States relate to the advent of the APOMM columns in 1980. The works are mentioned briefly, in chronologic order, to provide historical context for the columns. The physician stories in the APOMM columns are an outgrowth of the progression in medical training from largely science-based, to training more inclusive of the medical humanities. APOMM stories about the importance of understanding the patient as the core of patient-physician interaction are historically rooted in the publications described here.

In 1910, a document entitled "Medical Education In The United States and Canada: A Report To The Carnegie Foundation For The Advancement Of Teaching" (subsequently referred to as "The Flexner Report"), was authored by Abraham Flexner.[11] In an article about the Flexner Report written in 1974, Carlton Chapman explains that Flexner was an educator who conducted a survey of existing medical schools in the United States and Canada, later making observations and recommendations; Flexner consequently advocated grounding medical education in the sciences and in teaching hospitals.[12] Chapman, in a comment germane to this dissertation topic, explained that although Flexner's focus was the critical need for knowledge of the sciences to practice medicine, he made "surprisingly modern"[13] observations as well. Flexner wrote,

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[11] Abraham Flexner, *Medical Education In The United States and Canada: A Report To The Carnegie Foundation For The Advancement Of Teaching*, (New York City: The Carnegie Foundation For The Advancement Of Teaching, 1910): Bulletin Number Four.

[12] Carleton B. Chapman, *"The Flexner Report by Abraham Flexner,"* Daedalus 103, no. 1, Twentieth Century Classics Revisited (Winter 1974): 108.

[13] Ibid., 107.

> The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physician's horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient – at most to his patient's family; and it was almost altogether remedial. The patient had something the matter with him; the doctor was called in to cure it. Payment of a fee ended the transaction. But the physician's function is fast becoming social and preventive, rather than individual and curative.[14]

Although Flexner argued the need to standardize education and include hospital-based training, he seems to have recognized, as a lay person and over one hundred years ago, the need for physicians to be skilled in teaching and practicing preventive medicine in their care settings, acknowledging social influences on health and illness. Expanding the physician's view beyond the patient allows for greater understanding of the patient's illness within the setting of the patient's life, family and community. These ideas contribute to the stirrings of the medical humanities in medical education and practice.

Another publication a few years later encouraged physician readers to focus on appreciating each individual patient's circumstance to enhance care. Dr. Francis Peabody wrote "The Care of the Patient," published in *JAMA* in 1927. He echoed Flexner's discussion of the non-scientific component of medicine, writing, "The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences, but comprising

[14] Abraham Flexner, *Medical Education In The United States and Canada: A Report To The Carnegie Foundation For The Advancement Of Teaching*, (New York City: The Carnegie Foundation For The Advancement Of Teaching, 1910): Bulletin Number Four, 26.

much that still remains outside the realm of any science."[15] Dr. Peabody understood that science alone does not explain illness.

The blending of knowledge, perception and respect for the mystery of human response to illness contributes to comprehensive clinical care. The physician demonstrating intellectual acumen, appreciation of the patient, and recognition of the physical and psychological components of illness practices both the science and art of medicine: evidence of the medical humanities in relationships with patients. Dr. Peabody concluded his article with his oft-quoted lines: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."[16]

The next influence on medical education is the rise of the medical humanities, with a focus on the study of literature about medicine. Such literature involves medical themes, in works written by both physicians and lay authors. The literature is intended to expand students' understanding of patients and illness. Lindsay Holmgren et al reflect on the development of the medical humanities, writing in 2011: "Over the last thirty years, therefore, the creation and expansion of what was once broadly referred to as the medical humanities curricula in medical schools throughout North America and Europe has in varying ways and degrees included the study of literature as a constituent part."[17] Likely some of the medical students exploring literature in medicine in the 1960s and 1970s

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[15] Francis W. Peabody, "The Care of the Patient," Original publication date March 19, 1927, *JAMA* 88. Reprinted *JAMA* 252, no. 6 (August 10, 1984): 813.

[16] Ibid., 818.

[17] Lindsay Holmgren, Abraham Fuks, Donald Boudreau, Tabitha Sparks and Martin Kreiswirth,"Terminology and Praxis: Clarifying the Scope of Narrative in Medicine," *Literature and Medicine* 29, no. 2, (Fall 2011): 249.

became physician-writers of APOMM columns during their careers. The medical humanities as they relate to APOMM will be addressed later in this chapter.

In keeping with the early years of medical humanities instruction, Dr. George Engel (in 1977) added to belief in the importance of practicing medicine with both a humanistic and scientific approach to patients. He encouraged colleagues to care for the whole patient by proposing his "biopsychosocial model,"[18] expanding Flexner's biomedical (science-based) model of medicine to embrace the social context of the patient. This approach reinforces the idea of the science and art of medicine as tandem elements of clinical practice. Dr. Engel wrote,

> To provide a basis for understanding the determinants of disease and arriving at rational treatment and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the the physician role and the health care system. This requires a biopsychosocial model.[19]

The publications cited thus far began in 1910 and extended to Dr. Engel's expanded model of care in 1977. The authors addressed the need for physicians (in addition to their didactic training), to know the patient, the patient's familial and social milieu, and literature about illness, all to increase awareness and understanding of each patient's circumstance. Into this climate came the APOMM columns in 1980. Education in the medical humanities and the study of literature and medicine continued.

Two years later, in 1982, a journal entitled *Literature and Medicine* premiered. The introductory issue contained a reprint of an article by Dr. Edmund Pellegrino

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[18] George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (April 8, 1977): 132.

[19] Ibid.

(originally the introduction to a book edited by Enid Rhodes Peschel entitled *Medicine and Literature* published in 1980). Dr. Pellegrino argued the value of studying literature about medicine in order to learn how to practice more capably. He said,

> The patient's history that a physician writes is really a tale, the narrative of the patient's odyssey in the dismal realms of disease. The writer, too, must contemplate the same perplexities of being afflicted, which are part of being human. Illness is inextricably woven into the tapestry of every human life. No serious writer can avoid it entirely.[20]

Dr. Pellegrino, initially referring to clinical physician writing about patients, then turned the readers' attention to the writers of literature about medicine, reminding them that writers eventually become the subjects of their own personal illness stories.

In the same inaugural issue of *Literature and Medicine,* Larry Churchill wrote about the beneficial effect of studying literature to enhance medical practice, and the application of such heightened understanding about patients and people in general to clinical caregiving. He explained,

> In spite of the spectacular success of scientifically based medicine, many of the problems that physicians are called upon to treat do not yield to technical, scientific solutions. Suffering, depression, alienation, chronic disease, disability and death are non-technical-solution problems – problems of the human condition. They call less for the mastery of quantifiable factors in formal knowledge than for depth of insight, acuity of perception, and skills in communication – namely the sort of expertise that is traditionally associated with literature.[21]

Churchill's message centered on the importance of understanding the patient's circumstance. Just as Dr. Peabody focused readers on the patient, Churchill highlighted the need for the physician's interpersonal capabilities in patient care. He wrote in 1982 about universal conditions remaining prevalent in medicine today. While technology and

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[20] Edmund D. Pellegrino, "To Look Feelingly – the Affinities of Medicine and Literature," *Literature and Medicine* 1 (1982): 20. Originally published as the introduction to *Medicine and Literature*, ed. Enid Rhodes Peschel, xv-xix, New York: Neale Watson Academic Publications, 1980.

[21] Larry R. Churchill, "Why Literature and Medicine?," *Literature and Medicine* 1, (1982): 35.

treatment have progressed, some conditions cannot be remedied exclusively with science-based therapies. In such situations, the doctor's ability to understand and support the patient in relationship over time is essential.

Medical students and doctors hear progressive calls in the twentieth century first for scientific proficiency, then for awareness of the social influences on disease, fluency in the patient's individual circumstance and an appreciation for the universality of illness. Increasing awareness of patients as people, and appreciation for the many factors that contribute to illness experiences, are aimed at improving the capacity of doctors in clinical settings to understand patients. Such influences contribute to the premiere of "A Piece of My Mind" in *JAMA* in May of 1980, when doctors begin to tell stories about the people they care for, revealing their understanding and appreciation of patient-physician relationships for fellow physicians.

Publications After APOMM Related to Physician Storytelling

The interest in literature about medicine as a tool for understanding the patient experience continues after the start of APOMM. In 1987, Dr. Howard Brody wrote in his *Stories of Sickness*, "The primary human mechanism for attaching meaning to particular experiences is to tell stories about them."[22] He examined the significance, including in philosophical and ethical contexts, of illness stories. Patients explain their situations to doctors; doctors then document their understanding of the patient's circumstance for

[22] Howard Brody, *Stories of Sickness*, (New Haven: Yale University Press, 1987), 5.

colleagues and other healthcare professionals, identifying problems and formulating a plan of care; these explanations are ways of "attaching meaning" to the patient's story.[23]

The focus of studying literature in medicine is to increase understanding of illness through the reading of non-clinical works by both medical and lay writers, as a passive exercise. Once students understand illness more fully they learn to use such knowledge to interpret real-life patients, in active roles as professionals. Whether patients endure acute or chronic illness, medical or surgical intervention, living with illness or dying from it, clinical records capture their experiences. The doctors (and the healthcare teams) who create and maintain these records are restricted by the rules of medical writing.

The doctors' interpretation of the patient's story is the subject of Kathryn Montgomery Hunter's 1991 work entitled *Doctors' Stories: The Narrative Structure of Medical Knowledge*.[24] Hunter (a non-physician writer), examined the professional storytelling about patients done by physicians in clinical settings, in her book published eleven years after the start of APOMM. Her work provides a counterbalance to reading literature and medicine, that is, an examination of clinically required writing about patients by treating physicians.

Hunter identifies two versions of illness that emanate from patient-doctor interaction, explaining,

> The first, the patient's story, is the original motivating account that the person who is ill (or family or friends) brings to the physician; the second is the medical account constructed by the physician from selected, augmented parts of the patient's story and from the signs of illness in the body. The first concerns the

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[23] Howard Brody, *Stories of Sickness*, (New Haven: Yale University Press, 1987), 5.

[24] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure Of Medical Knowledge*, (Princeton: Princeton University Press, 1991).

> effects of illness in a life, the second the identification and treatment of a disease.[25]

Hunter echoes Dr. Peabody's focus on the importance of preserving the individuality of each patient and honoring each patient story. The doctor is tasked with retaining the essence of the patient version in a necessarily structured clinical adaptation.

Medical writing in clinical settings figuratively propels the patient through the illness experience. Physician understanding of the patient's story influences the physician's plan of care. The nature of the physician's interpretation of the patient influences the patient's trust and belief in the plan. The stories physicians tell each other in the hospital guide the process of caregiving, from beginning to end of patient hospitalization. Similarly, the clinical interpretations of patient stories shared with colleagues in outpatient settings affect the course of the treatment plan from patient visit to patient visit. Thus the meaning of these intertwined and ongoing exchanges between the parties bears directly on the nature of the resulting patient-physician relationship, and the patient's course.

The APOMM columns differ from the clinical writing doctors (and other members of the healthcare team), use and share in their work. The columns are not often the product of such group effort. Typically, they are created by single physician-writers and borne of recollections of patient encounters. The APOMM authors are under no obligation to write their stories, as is the case with medical records and charts. There are no time constraints on the writing in APOMM, while the clinical record is time-sensitive and regularly updated. The authors choose when, how and what to tell in their own

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[25] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure Of Medical Knowledge*, (Princeton: Princeton University Press, 1991), 13.

stories about patient relationships. The APOMM columns also provide a type of consultation arena for physicians; doctors (writers and readers) can express and explore their understanding of patient encounters, medical practice, and professional concerns. Physician-writers tell their colleagues things not written in the medical record. They write endings to stories begun in care settings, sharing them with physicians and medical students for different purpose than the medical record, and with language differing from the medical version of the story.

The uniform, succinct and technical clinical writing in the medical record contrasts with the columns of APOMM, where doctors write without similar rules. Hunter elaborates on the usual characteristics of medical writing by treating physicians, explaining, "In most other respects, the qualities of the chart write-up are qualities shared by medical narrative as a whole: its economy and immediacy, the effacement of the narrator with the consequent cool objectivity of tone, its claim to scientific status and its use of a special language."[26] The APOMM columns differ from didactic medical training in their realism. They differ from controlled clinical trials in their practicality. They differ from scholarly articles in their informal approach. They differ from standard medical charting in their personal and individual revelations. In clinical and research writing, doctors practice the science of medicine, but in the APOMM columns they practice the art of medicine.

In many cases, the doctors share feelings they would not be able to share with their patients, sometimes showing a vulnerability not seen typically in the clinical setting.

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[26] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure Of Medical Knowledge*, (Princeton: Princeton University Press, 1991), 91.

Dr. Jennifer Frank writes in 2012 of her thoughts just before she must give biopsy results to a woman about to learn she has breast cancer. Dr. Frank pauses, feeling,

> I want to tell you to wait. Wait just a minute. This moment, this before is the last one you'll have. When I tell you what I have to tell you, life will irrevocably change. The prism through which the light of your life diffuses will be different. How you look at your children will be different. What makes you smile or cry or laugh or weep will be different. Everything will be different.[27]

Dr. Frank puts the weight of her professional task in words for her colleagues; certainly many have been in similar situations and can empathize. But she also puts her personal feelings as a woman about to change another woman's life into her story. Perhaps the patient would find the doctor's expression unsettling, but perhaps such intimacy between doctor and patient would be comforting to both. Dr. Frank understands the ramifications of a breast cancer diagnosis and writes about how she tries to give the patient her diagnosis as gently as she can. It is as though because she knows she cannot reveal her emotions to the patient, she tells her colleagues instead.

In caregiving settings, the doctor assesses the patient and makes observations in the medical record. Hunter describes the doctor as the interpreter of the patient's story, noting: "They are also highly trained, critical readers of the text that is the patient."[28] Conversely, physician-writers share different observations and interpretations of patient encounters in APOMM. The language is less scientific, and more of the physician's personal thought is in evidence compared to the clinical chart. The columns about patient-physician relationships are a subsequent, non-clinical corollary to the observations initially made in the healthcare setting. The two related stories are akin to

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[27] Jennifer Frank, A Piece of My Mind, "The Before," *JAMA* 307, no. 9 (March 7, 2012): 921.

[28] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, (Princeton: Princeton University Press 1991), 4.

the dyads that constitute literature and medicine, patient and doctor, writer and reader, science and art.

Hunter recognized the appearance of non-clinical writing by physicians in venues such as APOMM, appreciating the importance of the physician's voice in such stories. She observed,

> Increasingly during the 1980s such accounts appeared in medical journals where they offer psychic refreshment and moral encouragement to members of a profession that has not traditionally fostered self-disclosure. Being a physician is hard work. These narratives about doctoring, especially in a time of change, are valuable for representing the subjective experience of physicians meeting difficult patients, puzzling or frightening patients, patients who may sue. . . [S]uch reports "from the trenches" tell us something never included in the medical case history: the physician's thoughts and feelings about the medical encounter. Here the physician is free to speculate – still in the context of the care of a patient – about such matters as the creation of the therapeutic relationship and its effects, the interaction of mind and body, and the mutual influence of the illness and the character of the person who is ill.[29]

Another development in medical education relates to the APOMM columns as expressions about the importance of physician understanding and perception in the patient-physician relationship. Dr. Rita Charon conceptualized what is now called narrative medicine, and defined the term as comprising five types of non-clinical storytelling by doctors. They are: 1. medical fiction (fictional accounts of illness or caregiving experiences by physician-writers), 2. the lay exposition (physician writing specifically for lay audiences in newspapers and periodicals), 3. medical autobiography, 4. stories from practice (such as the APOMM pieces) and 5. writing exercises of medical

[29] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, (Princeton: Princeton University Press 1991), 163.

training (students write about their experiences and often share their accounts with fellow students).[30] She observes about stories from practice,

> Essays in these columns differ from lay exposition and medical autobiography in audience and intent. Because physicians write these essays for other physicians to read, they adopt the narrative stance of the insider, expecting their readers to pick things up between the lines. Physicians write such essays to present unique experiences to colleagues, to brood aloud to others like themselves, and, sometimes, to seek forgiveness for perceived lapses.[31]

The APOMM authors express themselves as Dr. Charon describes, but in additional ways as well, including to honor and memorialize special caregiving moments with patients and explore the variability in patient-physician relationships.

Medical Humanities and the Connection to APOMM

The inclusion of humanities study in medical education starts in the early 1970s according to Lindsay Holmgren et al.[32] Dr. Howard Brody places the beginning of medical humanities education at about that time, writing, "While the oldest programs in medical humanities within US medical schools date back to the 1960s and 1970s, defining 'medical humanities' remains a challenge."[33]

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[30] Rita Charon, Medical Writings, "Narrative Medicine: Form, Function, and Ethics," *Annals of Internal Medicine* 134, no. 1 (January 2, 2001): 83-84.

[31] Ibid., 84.

[32] Lindsay Holmgren, Abraham Fuks, Donald Boudreau, Tabitha Sparks and Martin Kreiswirth,"Terminology and Praxis: Clarifying the Scope of Narrative in Medicine," *Literature and Medicine* 29, no. 2, (Fall 2011): 249.

[33] Howard Brody, "Defining the Medical Humanities: Three Conceptions and Three Narratives," *Journal of Medical Humanities* 32, (2011), 1.

The medical humanities encompass many subjects, and one current description is found on the website of the Division of Medical Humanities in the Department of Medicine at the New York University School of Medicine. It reads,

> We define the term "medical humanities" broadly to include an interdisciplinary field of humanities (literature, philosophy, ethics, history and religion), social science (anthropology, cultural studies, psychology, sociology), and the arts (literature, theater, film, multimedia and visual arts) and their application to healthcare education and practice. The humanities and arts provide insight into the human condition, suffering, personhood, and our responsibility to each other. They also offer a historical perspective on healthcare. Attention to literature and the arts helps to develop and nurture skills of observation, analysis, empathy, and self-reflection – skills that are essential for humane healthcare. The social sciences help us to understand how bioscience and medicine take place within cultural and social contexts and how culture interacts with the individual experience of illness and the way healthcare is practiced.[34]

For those attempting to understand the medical humanities, the definition above relates to the writing in APOMM. The columns began in 1980, and their publication now overlaps study of the medical humanities by almost forty years. The authors write about patient-physician relationships as seen through their individual lenses, with their personal perspectives colored by life experience, training and clinical practice. The stories also include an understanding of the patient's circumstance, involving for example, social and cultural influences on illness, the psychology of the patient role, and philosophy and ethics regarding healthcare access and funding.

A different view about the medical humanities came in 2005 from Dr. Raphael Campo. He wrote with disappointment that while he and his colleagues looked

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[34] NYU School of Medicine, NYU Langone Medical Center, Division of Medical Humanities, Department of Medicine, "Literature, Arts, and Medicine Database," *About The Database*, Humanities, Social Sciences & The Arts in Relation to Medicine & Medical Training, accessed February 12, 2017, http://medhum.med.nyu.edu/about.

"instinctively to the humanities as a source of renewal, reconnection, and meaning"[35] he was not certain that the medical humanities as a concept offered such consolation. Rather, he wrote,

> It neither asserts the goal of educating aspiring physicians to be more empathetic, as we cannot invoke the word "medical" without automatically thinking of today's dominant, antiempathetic biomedical approach to treating patients, while "humanities" fails to stipulate just what in so far-reaching a realm is truly relevant to the ill and their care providers. It seems as a construct utterly exhausted, attenuated by decades of trying to encompass all that the invincible biomedical model of medicine actively ignores; it even risks sounding petty and adversarial, as if medicine were unremittingly inhumane. . . [N]o conception of "the medical humanities" compels, caught somewhere between manifesto, mushiness, and marketing lingo.[36]

This dissertation argues the APOMM columns are, if not conceptually defining of the medical humanities, straightforward and instructional examples of the humanities in medical practice, in stories about the importance of the patient-physician relationship. The authors of APOMM share their views, broadening reader understanding with the weekly delivery of non-clinical writing about patients and evidence of the humanities in medicine.

For example, in 1987 Dr. Jack Mayer wrote about his practice in a rural Vermont community at the Canadian border. The piece, entitled "Twelve Brown Eggs" is about the doctor's experience after he invited his patients to barter, knowing that the economy of the area prevented many from paying their bills.[37] The doctor appreciated the social needs of his neighbors while comprehending their medical needs when they became his

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[35] Rafael Campo, A Piece of My Mind, " 'The Medical Humanities,' for Lack of a Better Term," *JAMA* 294, no. 9 (September 7, 2005): 1009.

[36] Ibid.

[37] Jack L. Mayer, A Piece of My Mind, "Twelve Brown Eggs," *JAMA* 257, no. 8 (February 27, 1987): 1098.

patients. He was insightful about their predicaments. Such recognition and respect fosters relationships between patient and physician by placing the patient's illness into the context of the patient's life. Dr. Mayer described specific patients, but his story was about recognizing social influences on his practice, adapting to the needs of his community, and creating an honorable way for his patients to accept his care. His story exemplifies the medical humanities.

Physician-Writers: Thoughts On Their Own Writing

The personal recollections of caregiving experiences by physician-writers are a rare form of storytelling. Although physician-writers are an expanding population, their numbers are small relative to the general physician population. One is reminded of the thousands of conversations between patients and doctors that take place every day, in every type of care setting. Yet the majority of those stories remain in the clinical records and in the minds of physicians, not in the pages of APOMM or other non-clinical physician storytelling spaces. Thus the published accounts by physician-writers, from their unique positions caring for ill people, makes their writing compelling. The wealth and sheer volume of patient stories doctors interpret daily in professional arenas creates a potential reservoir of personal stories for doctors choosing to write.

Motivation and purpose for writing are individual and private matters for any author. While it is sometimes possible to know the clinical specialty, gender and approximate age of the APOMM physician-writer and make presumptions from that information, it is usually impossible for a reader to know the motive or intent of the writer. Two sources for gaining understanding of physician-writer motivation are

columns in medical journals where physician-writers are invited to explain why they write about practice. The columns are not like APOMM. Rather, they specifically seek explanations from authors regarding their decisions to write about medicine non-clinically, sharing their insights. The journals and columns are described briefly here to provide information about physician-writer motivation.

In 2001, *Annals of Internal Medicine*, a medical journal published in the United States by the American College of Physicians, introduced a series called "Medical Writings: Physician-Writers' Reflections On Their Work." The editors, in introducing the series, wrote,

> In recent years there has been a steadily growing interest in the narrative aspects of medical practice, as well as in doctors' writings about their work. Underlying this interest is the assumption that careful attention to the language and stories of medicine can enrich the doctor-patient relationship, improve patient care, and enhance doctor's sense of satisfaction with their work.[38]

In the subsequent inaugural column, Dr. Abraham Verghese describes doctors' places in patient stories: "we are characters in various stories, walking on and off the stage in the tales that take place in our hospitals and clinics."[39] This observation supports the ongoing and changing nature of the relationship between patients and physicians, as the patient's report of illness, the doctor's diagnosis, the doctor's treatment plan and the patient's response to such treatment are perpetually evolving. Dr. Verghese explains that doctors inevitably become part of the patient's story, but also that "we as physicians

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[38] The Editors, American College of Physicians, American Society of Internal Medicine, Medical Writings: Physician-Writers' Reflections On Their Work, "The Physician as Storyteller," *Annals of Internal Medicine* 135, no. 11 (December 4, 2001): 1012.

[39] Abraham Verghese, Medical Writings: Physician-Writers' Reflections On Their Work, "The Physician as Storyteller," *Annals of Internal Medicine* 135, no. 11 (December 4, 2001): 1012.

create stories as often as we record them."[40] When applied to APOMM, his observation helps explain the authors' decisions to share their personal thoughts about patients with fellow physician readers of *JAMA*.

In 2003 (two years after *Annals of Internal Medicine*), another medical journal entitled *The Lancet* (published in the United Kingdom since 1823) initiated a feature called "Dissecting Room: Physician writers." The column focuses not on physician thoughts about patients or practice, as is often the case in APOMM, but on literature and medicine and the authors' own writing. Several of those who are published in the column continue to write today. Among them, Dr. Danielle Ofri sensitively elucidates the connection between practicing medicine and writing about patients, stating that physician-writers must,

> treat the stories of our patients in the same way that we treat our patients, realising that we are privileged to lay our hands on both the bodies and the souls of those who come to us in need. We must probe the patient's story as gently as we palpate their abdomen, never going beyond the point of wincing, never causing pain for pain's sake. We must listen for the human underpinnings as delicately as we listen for diastolic murmurs. We must examine the tender edges of despair as gingerly as we would explore the ragged edges of a wound. And then we must look the patient - and their story - directly in the eye at the end of the encounter, and ask ourselves if we have made a connection that is healing. . . Then, and only then have we become part of the patient's story.[41]

Dr. Ofri holds the patient's story and the patient's body in equal reverence, making the story seem a living entity, requiring as much careful handling and understanding as the patient it comes from. But the other message of her column is about earning a place in the

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[40] Abraham Verghese, Medical Writings: Physician-Writers' Reflections On Their Work, "The Physician as Storyteller," *Annals of Internal Medicine* 135, no. 11 (December 4, 2001): 1012.

[41] Danielle Ofri, Dissecting Room, "Physician writers, Danielle Ofri" *The Lancet* 361 (May 3, 2003): 1572.

patient's story, mandating respect for patients as the prerequisite for caregiving *and* storytelling.

The doctors who share their thoughts about their own writing in "Medical Writings: Physician-Writers' Reflections On Their Work" and in "Dissecting Room: Physician writers" offer insight into why physicians reveal personal thoughts about patients and practice. Such revelations serve readers of APOMM, and other works by physician-writers, inviting them into the minds of doctors telling stories about caring for patients in the imperfect and unpredictable setting of modern healthcare.

Storytelling Venues in Professional Medical Journals

Two professional medical journals other than *JAMA* offer physicians an opportunity to write non-clinically about medicine. They are described briefly for comparison to APOMM, and to give scope to such writing. Ten years after the start of the APOMM columns in *JAMA*, the *Annals of Internal Medicine* (published by the American College of Physicians) began a feature entitled "On Being A Doctor" with the December 1, 1990 issue. Submissions initially were limited to 2500 words; current submissions cannot exceed 1500 words.[42] The editors explained their intent in publication, along with advice to authors in an introduction to the first column as follows,

> Even under ordinary circumstances, interactions between doctors and patients are extraordinary because so frequently the act of doctoring requires patients to expose intensely private aspects of their minds and bodies. Doctors, as well as patients, are profoundly affected by these interactions, in both positive and negative ways. Although most strive to distill meaning from the daily experiences of being a doctor, only some, through gift and training, have the ability to describe them with remarkable clarity. The best writers remind physicians of the

[42] American College of Physicians, *Annals of Internal Medicine*, "Information for Authors – On Being a Doctor," accessed February 12, 2017, http://annals.org/aim/pages/authorsinfoonbeingadoctor.

> special meaning of being a doctor; perhaps such a reminder is particularly needed in these times of bureaucratic frustration.[43]

Twenty-seven years after inauguration of the column, the bureaucracy is more intense, regulations are broader in scope, yet physicians continue to write about their relationships with patients in various venues despite such challenging influences on clinical practice. The *Annals of Internal Medicine* is published twice monthly and the "On Being A Doctor" feature is not always included. *Annals* is available to members of the American College of Physicians, numbering approximately 148,000 (with additional readers worldwide), according to the College.[44] Other readers access the journal online.

The *New England Journal of Medicine* (*NEJM*) is produced by the Massachusetts Medical Society and began a column in January 2002 entitled "Perspective." According to the guidelines for authors, the "Perspective" column (limited to approximately 1200 words) includes a range of topics, "from health policy to bioethics, from global health to the history of medicine, from health law to physicians' personal experiences in training and practice."[45]

Compared to APOMM and "On Being a Doctor," the "Perspective" column is not necessarily about patient-physician relationships or personal sentiment about practice; some columns focus on clinical topics and issues. In describing the nature of the more personal pieces sought for the column, the guidelines state, "We also publish personal essays and narratives that resonate with readers while providing new insight into the

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[43] The Editors, "On Being A Doctor," *Annals of Internal Medicine* 113, no.11 (December 1, 1990): 820.

[44] American College of Physicians, *Annals of Internal Medicine*, "About *Annals of Internal Medicine*," accessed February 12, 2017, http://annals.org/aim/pages/about-us.

[45] *New England Journal of Medicine*, "Author Center; Writing Perspective Articles," accessed March 4, 2017, http://www.nejm.org/page/author-center/perspective-submission.

kinds of experiences they share, dread, enjoy, ruminate over, or have heretofore not consciously analyzed."[46] The *NEJM* editors explain what they seek for inclusion in the "Perspective" column, addressing members interested in writing about the positive and negative facets of being a doctor, and encouraging authors to express thoughts they may be hesitant to share. The *NEJM* is read by more than 600,000 people in 177 countries.[47] Additional readers access *NEJM* content online.

The *Journal of the American Medical Association*, the *Annals of Internal Medicine* and the *New England Journal of Medicine* are medical publications from the United States with worldwide distribution. Collectively they reach over one million physician readers (in print form) in the United States; this number does not include international readers and those with online access. Of the over 926,000 licensed physicians in the United States,[48] it is difficult to know how many read any or all of these non-clinical columns by their medical colleagues. Practicing physicians (and an additional number of retired physicians and medical students) have access to these three different journals for expressions of thought, emotion and personal philosophy from physician-writers. The readers learn about perspectives on medicine from both students and practitioners; students read pieces by experienced physicians, while practicing physicians maintain a connection to the challenges of student-writers preparing to practice some day.

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[46] *New England Journal of Medicine*, "Author Center; Writing Perspective Articles," accessed March 4, 2017, http://www.nejm.org/page/author-center/perspective-submission.

[47] *New England Journal of Medicine*, "About NEJM; Past and Present," accessed March 4, 2017, http://www.nejm.org/page/about-nejm/history-and-mission.

[48] The Henry J. Kaiser Family Foundation, "Total Professionally Active Physicians," (September 2016), accessed February 12, 2017, http:/kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0.

Physician Storytelling in "A Piece of My Mind"

Physicians tell stories, just as all people engage in some form of storytelling as part of the human experience. Stories allow people to share information or feelings, express hope or fear, rally or calm readers. APOMM author Dr. Harriet Squier explains her need to write in a column from 1996 entitled "Haying," describing the pleasure of visiting her father's farm to help with cutting the hay. She compares her physical fatigue after helping on the farm to her emotional fatigue after a day with patients.[49] She writes: "I feel heavy after a day's work, as if all my patients were inside me, letting me carry them. I don't mean to. But where do I put their stories? The childhood beatings, ulcers from stress, incapacitating depression, fears, illness? These are not my experiences, yet I feel them and carry them with me."[50] Dr. Squier gives palpable dimension to her patients' stories, attributing weight and mass to them as she describes feeling their effect in an almost tangible way. The physical labor of haying relieves her emotional fatigue when the bulk of the patient stories exhaust her. She concludes,

> I've needed to feel this heaviness in my muscles, the heat on my face. I am taunted by the simplicity of this work, the purpose and results, the definite boundaries of the fields, the dimensions of the bales, for illness is not defined by the boundaries of bodies; it spills into families, homes, schools, and my office, like hay tumbling over the edge of the cutter bar. I feel the rough stubble left in its wake. I need to remember the stories I've helped reshape, new meanings stacked against the despair of pain. I need to remember the smell of hay in June.[51]

Dr. Squier uses the haying to settle herself. Her comparison of the spilling hay to the spilling of illness is a vivid description likely understood by other doctors and healthcare

[49] Harriet A. Squier, A Piece of My Mind, "Haying," *JAMA* 275, no. 2 (January 10, 1996): 99.

[50] Ibid.

[51] Ibid.

professionals who hear so many stories each day. She shares her problem and her remedy with readers.

The APOMM columns illustrate the connection between physician-writers and their patients, preserving the essential element of forming and maintaining a relationship central to medicine. One author defines connection in the ways he shares the patient's physical space. Dr. Donald Misch writes in 2016: "Indeed how important is nonverbal communication in the practice of medicine! Sitting down or standing up when speaking with a patient, a direct gaze or downcast eyes, a touch on the arm, a smile – these are crucial components of the skilled physician's communication toolbox."[52] An element of unspoken interaction is central to this doctor's interpretation of how to be with a patient. His opinion of such exchanges would not be recorded in the patient's medical record, but the doctor can tell his colleagues about the importance of these encounters in APOMM, as examples of understanding and connection in medicine.

The individuality of the patient's clinical circumstance determines the patient's story, which in turn influences the doctor's interpretation of the patient-physician encounter. Healthcare professionals may help ten patients with abdominal pain but each patient's description of the pain, the course of the pain, factors that aggravate or alleviate the pain and the severity of the pain will be different. The ability to appreciate the differences among patients is essential to a caring relationship between the person who needs help and the caregiver, and each caregiver will interpret the patient's story in an individual way. One APOMM column is about a project conducted with HIV-infected young adults asked to tell their stories. The narratives were recorded, and transcripts were

[52] Donald A. Misch, A Piece of My Mind, "I Feel Witty, Oh So Witty," *JAMA* 315, no. 4 (January 26, 2016): 346.

also made for the use of medical students and clinicians interested in listening to, or reading patient narratives. The authors closed with,

> In the din of the health care policy debate, let us remind ourselves of who we should be listening to – our patients. Their voices are powerful, their stories are compelling, and listening to them not only helps other patients see the light at the end of the tunnel but also allows their care professionals to remind themselves of who they are caring for and why it is so important. . . [A]s you go around practicing medicine, take time to pause, listen, and share your patients' voices. Every ill body is a storyteller waiting to share.[53]

Although the project described above was for medical students, the observations of the authors apply to APOMM: a non-clinical writing space for physicians sharing stories from patient encounters, each in their own particular time, tone and with a specific message for their colleagues.

In some cases, communication between patient and physician is exemplified as mutual support. Dr. Kimberly Ephgrave wrote about some of her patients, and her own experience as a patient. She shared memories of two particular patients with overwhelming medical problems who remained positive and optimistic, using those recollections to fortify her own optimism despite her poor prognosis. Dr. Ephgrave wrote: "As they are for many others in health care, patient stories are my way to think. . . Perhaps these particular stories are also a form of full disclosure, in that these stories are part of me. The thousands of patients with fixable problems shaped me collectively, but these individual persons influenced me distinctively."[54] While Dr. Ephgrave was sharing

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[53] Kathryn A. Cantrell, Sylvia Sutton and Aditya H. Gaur, A Piece of My Mind, "Pause, Listen, Share," *JAMA* 312, no. 4 (July 23/30, 2014): 346.

[54] Kimberly S. Ephgrave, A Piece of My Mind, "Maintenance, "*JAMA* 304, no. 6 (August 11, 2010): 616.

her medical acumen with her patients, she was gathering strength from them. Her column is a thank-you note.

The voices of doctors typically carry the stories to readers of APOMM, and sometimes patients are given voice in the columns as well (whether quoted directly or paraphrased by the authors). The physician-writers of APOMM also use a variety of narrative voices to tell their stories. One column is written in the second person voice, and is a farewell letter from an anesthesiology resident to her brain dead, organ donor patient. Dr. Louise Wen describes her repeated realization that her patient does not require the usual preparation for surgery related to sensations and awareness; he does not have such feelings or thoughts because his brain no longer functions. She writes about not needing to medicate the patient before transport to the operating room, or pad his extremities for comfort, or administer anesthetic agents.[55] Additionally, this physician's usual interpersonal skills are not required, since her patient is unable to communicate.

Yet Dr. Wen's column is about the connection she has to the patient; she writes at the end of the harvest procedure, "Our patient-physician relationship ends here."[56] In a wordless encounter, the physician perceives she is part of a relationship. Her responsibility to care for the patient, and form something she would define as a relationship, is important to the author. She uses her APOMM column to tell her colleagues what happens, as if to honor the presence of the patient in body, even though he no longer exists as a sentient being.

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[55] Louise Wen, A Piece of My Mind, "Meeting the Organ Donor," *JAMA* 315, no. 11 (March 15, 2016): 1111.

[56] Ibid.

Dr. Wen explains that during the "time out" now common in operating rooms when preparation stops in order to confirm the correct identity of the patient and the procedure about to be performed, notes to the patient from his family are read aloud.[57] As the donor's family reaches out to their lost loved one, to whom they must say goodbye, so Dr. Wen sends her story out to her colleagues about a patient she cannot reach, but to whom she is connected through professional responsibility and emotional response. Although the patient is cognitively gone, he is at the center of Dr. Wen's story.

Each story in APOMM expands the readers' conceptualization of the patient-physician relationship. Most of the APOMM stories about such relationships involve cognitively unimpaired patients, capable of communicating in some fashion (verbal or non-verbal), and physicians interested and engaged in understanding the patient's story. A different communication and relationship dynamic exists with patients who cannot communicate, either due to young age (infants, small children), emergency situations, or cognitive impairment from condition, illness or injury. Some columns are about relationships between patients and physicians that do not involve conventional conversation (such as the story from Dr.Wen), and sound as genuine as those involving verbal exchange.

The APOMM writers are a subset of doctors clearly interested in sharing their thoughts about the importance of patient-physician relationships with their colleagues. Alternatively, some patients and physicians do not seek relationships beyond the practical. Some patients want only a test, procedure or prescription, while some doctors do not engage in conversation or demonstrate any particular interest in the patient beyond

[57] Louise Wen, A Piece of My Mind, "Meeting the Organ Donor," *JAMA* 315, no. 11 (March 15, 2016): 1111.

establishing a diagnosis, formulating a treatment plan and giving routine care. The APOMM authors referenced in this dissertation are a self-selected group choosing to write about the importance of understanding patients, families and communities in their clinical relationships.

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The stories in APOMM are part of a storytelling tradition in medicine influenced by the evolution of modern medical education and practice over the last one hundred years. The study of literature and medicine, the medical humanities and narrative medicine is intended to fortify clinical understanding in medical students and practicing physicians. Such understanding, the art of medicine, is manifest in the non-clinical physician writing in APOMM. The columns come from physicians in all phases of their careers, in stories about perceiving patients in medical practice. At the close of this chapter the "when" and "where" of non-clinical physician writing about medicine in select professional journals have been addressed.

Remaining chapters address the "what" and "how" of the writing in APOMM. Each chapter focuses on a particular feature of how physicians understand patients: ways to enhance appreciation of the patient condition, circumstances that limit or prevent interpersonal engagement with the patient, features of clinical practice (data gathering and the electronic medical record) that challenge physicians in their efforts to perceive patients as unique individuals with unique stories, and perspective gained from becoming patients themselves. The columns cited in each chapter span the publication years of APOMM, demonstrating consistent interest of physician-writers, *JAMA* editors, and physician readers in understanding patient-physician relationships.

Each physician choosing to write under the heading “A Piece of My Mind” is not simply saying “I want to tell you a story,” but “I need to tell you *this* story.” Such stories offer a distinct interpretation of the art of medical practice not found in clinical writing, preserving and illuminating physicians’ thoughts about people who are patients, and the patient-physician relationship.

CHAPTER TWO

FACTORS THAT ENHANCE PATIENT-PHYSICIAN RELATIONSHIPS

This chapter concerns factors that enhance patient-physician relationships in the eyes of APOMM physician-writers. The authors describe their bonds with patients, often in terms of what they learn from such experiences. The physician-writers are aware of their patients as people, documenting their understanding of patients, their families, and in some cases their communities. Thus the stories about human behavior and response to illness include author perspective on philosophy, psychology and sociology, as examples of the humanities in medicine.

The columns span almost the entire publication period of APOMM (1982 through 2012), demonstrating ongoing writer and reader interest. Approximately fifty-five columns were considered for this chapter; ultimately twenty columns were included, representing physician awareness of enhancing features in patient-physician relationships. Regardless of various changes in medicine over time (technologic, administrative, social, political), the writers consistently choose positive and beneficial features of their time with patients as the subjects of their columns.

Forming relationships is usually a desirable goal of encounters between patients and doctors, with varying results. Patient-physician meetings may involve two strangers or two people known to each other; they come together by circumstance and need, in a range of visits, from brief appointments for minor problems to visits for illnesses, procedures or hospitalizations. The encounters can be scheduled or random as in urgent cases. Some patients seek out specific doctors based on the recommendations of family, friends or colleagues, but others meet their doctors in unexpected or emergency situations

with no choice of particular caregiver. Patients present to them in offices, clinics and hospital rooms, where the doctor's responsibility might be to either engage a stranger in conversation or greet a patient known from past visits. There is inherent uncertainty about the type of relationship that develops between any one patient and any one doctor, and relationships change over time. Columns about patient-physician relationships are the focus of many APOMM authors in part because of the fluidity, uncertainty and variability of patient-physician dynamics.

Positive patient-physician relationships involve two parties willing to engage in verbal or non-verbal communication, hoping that a mutually satisfying encounter ensues. It is naïve to think that all patients or physicians approach each other wanting such interaction. Patients may be disinterested in the advice of a doctor, or hostile towards the doctor. Doctors may be similarly disinterested, distracted, or disengaged from patients. These are not likely the doctors who write in APOMM. Rather, the physician-writers in APOMM tell stories about their varied and creative interpretations of relationships with patients. The columns show the emotional richness possible in medicine. The volume, duration and scope of the stories provides readers with a wide range of physician appreciation for the patient-physician relationship.

Appreciating Patients as People

Patients are people with illness, defined not exclusively by their diagnoses, but also by the roles and responsibilities in their lives. This is a revelation to some APOMM writers. In caring for patients, they receive lessons about factors influencing individual patient response (physical and psychological) to sickness, including family dynamics,

work habits, lifestyle choices and leisure pursuits. The treating physician's interaction with the patient adds another variable to the multi-factorial experience of illness. Spending time to learn about the patient, and the many influences on patient health, requires interpersonal skill and investment by the physician.

Learning to see the patient as a person involves more than the doctor's clinical acumen. One APOMM writer recounted his experience almost forty years after the fact. Dr. Clifton Meador wrote in 1992 about the lesson he learned from a patient he cared for during residency in the 1950s.[1] The child, Amy, was eleven years old and a brittle diabetic; Dr. Meador's efforts to stabilize the child's disease were unsuccessful. After an absence of several months, Amy and her mother returned to clinic where she was found stable and well; the mother explained that although they could not be sure, she and her family noticed the girl's diabetes became manageable after she began to babysit for a child new to their neighborhood, and after her family acquired a kitten.[2] Dr. Meador wrote,

> So Amy initiated the expansion of my narrow model of disease which had been far too constricted into the abstractions of chemistry and physics. My experience with her reaffirmed the truth of the old statement: It is as important to know the person *with* the disease as it is to know the disease. To this we should remind ourselves and add: It is equally important to know about the people, the places, the things, the beliefs. . . even the small animals that surround the person with the disease. . . [N]othing clinical occurs in isolation.[3]

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[1] Clifton K. Meador, A Piece of My Mind, "The Person *With* the Disease," *JAMA* 268, no. 1 (July 1, 1992): 35.

[2] Ibid.

[3] Ibid.

The doctor appreciated that changes in the child's environment, social setting and responsibilities likely contributed to her improvement, by understanding her illness in the context of her life.

Discerning patients as people is challenging in the largely quantitative, science-based curriculum and practice of medicine. Dr. John Frey, who authors several APOMM columns, directs his words on this subject to medical student readers. His column is about the preponderance of applicants to medical school including a phrase in their application essays about their fascination with the human body.[4] Dr. Frey counters that his interest is in human beings rather than their bodies, writing in 2000,

> In all cases, the body is the vehicle for the person we meet inside it, letting us marvel at the soul that inhabits a damaged person or the lack of one in someone whose physical appearance is perfect. Medicine is the people we meet along the way – pain, worry, or suffering provides the excuse to meet them.[5]

Dr. Frey embraces the complexity of human beings who become patients. He observes, "What is true about medicine is that human beings, not human bodies, have the ability to dazzle us with their unpredictability."[6] Dr. Frey is enlightened by patient encounters, sounding as though he finds the uncertainty of human interaction invigorating.

APOMM writers remind readers that learning to see patients as people is essential to understanding that medicine is about people caring for other people, and not only physicians caring for patients. Dr. Eliezer Van Allen recalls, in 2011, the patient who reminds him of the need to see the patient as a person. He writes,

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[4] John J. Frey III, A Piece of My Mind, "I Have Always Been Fascinated . . .," *JAMA* 284, no. 18 (November 8, 2000): 2295-96.

[5] Ibid.

[6] Ibid., 2296.

> After three years spent honing and mastering skills aimed at dissecting complex patient issues into a bulleted list of problems requiring actions to accomplish goals, I foolishly lost sight of the fact that behind this list was an infinitely complex human being, unable to be broken down into manageable bits for my own intellectual convenience. . . [T]he patient is not merely a collection of parts needing adjustment but in actuality a whole entity, with needs befitting a fellow human being that we could all understand in our own lives.[7]

Such fellowship is the essence of understanding patients in practice, and each section of this chapter focuses on factors that contribute to greater physician recognition of patients as persons, each with their own special set of circumstances and expectations.

Listening to Patients

Once a patient is recognized as a person, the physician must establish communication with that person. People learn from each other in conversation if they know how to listen and respond to what they hear. Relationships are formed not when people talk at each other, but in the art of conversation, when one speaks while another listens, absorbing what is said and pausing to respond thoughtfully. Successful communication also involves other observable factors including eye contact, facial expression, speaking style, physical presence and setting or environment, in addition to less tangible interpersonal factors that determine how people get along. Several APOMM authors write about many ways to listen to patients, and the resulting benefits they receive from knowing how to listen.

Early in the life of APOMM, Dr. John Coulehan (who contributed several columns) writes about the doctor's role as listener, by considering the expression frequently used in medicine by doctors to describe a patient who cannot provide all of the

[7] Eliezer M. Van Allen, A Piece of My Mind, "Paracentesis by Moonlight," *JAMA* 305, no. 16 (April 27, 2011): 1636.

information the doctor seeks to make a diagnosis: such a patient is referred to as a "poor historian." Dr. Coulehan uses his 1984 column to warn his colleagues about using the term, and to suggest they take time to appreciate the patient's story. He remarks,

> The first avenue we could explore is the process of communication itself. On the doctor's part, that means slowing down to listen. We must develop an ear for meaning, speech patterns, and intent, just as we train our ear to detect the subtleties of cardiac auscultation. . . No doubt, there will always be poor historians in medicine, but, if we pay more attention to the clinical art, fewer of them will be the doctors.[8]

Dr. Coulehan writes in language his readers understand about a term they use in daily practice. His example is practical and delivers a specific message about taking care in listening to what patients say in their conversations with doctors.

Dr. Coulehan's reference to listening as part of "the clinical art" is found in the columns of other APOMM writers offering unique perspectives on how to listen to patients.[9] In addition to listening to what is said, the doctor must also listen to how patients express themselves. One APOMM physician writes about his relationships with patients from the perspective of using their own words to describe what is wrong. Dr. Arnold Wagner, writing in a column from 1988, believes in retaining the vivid language patients use to explain what is awry, rather than substituting medical terminology to describe the situation. Examples of patients' words include a woman describing her urinary tract infection: "It feels as though I am giving birth to a flaming lobster."[10] Another woman explains her dizziness by reporting, "I felt I'd fall off the floor and had

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[8] John L. Coulehan, A Piece of My Mind, "Who Is the Poor Historian?," *JAMA* 252, no. 2 (July 13, 1984): 221.

[9] Ibid.

[10] Arnold Wagner, A Piece of My Mind, "Listen to the Picture," *JAMA* 259, no. 3 (January 15, 1988): 420.

to hang on to the carpet."[11] Such descriptions would likely not appear in medical records, and their inclusion in an APOMM story broadens the reader's understanding of patient symptoms. Dr. Wagner appreciates the benefits of preserving patient language, writing about one woman's explanation,

> There is just no doubt that she has managed to describe a degree *beyond* severe, and we all fully understand this through her inventive presentation. . . All [such patient descriptions] enlist our sympathetic attention and focus the interrogation that must follow. They also capture our interest and so promote a keener investigative effort on our part, an effect that nourishes the symbiosis existing between patient and physician in the delineation of a complaint.[12]

The doctor suggests the patient's language prompts the healthcare team to try harder to understand what is happening by working more closely with the patient. The claim may be true, and Dr. Wagner's opinion raises questions for readers about the quality of care for patients with less colorful descriptions of their symptoms.

The columns about the importance of listening to patients and preserving their language shed light on conversational transactions between patients and doctors. Often such exchanges involve the doctor asking the patient a series of questions to try to ascertain the problem. But patient answers to questions (either written or verbal) are usually recorded in the medical language studied by Kathryn Montgomery Hunter and described in Chapter One. The nuance and detail of the patient's story is replaced by entries dictated in standard forms or the electronic medical record (the subject of Chapter Four). The APOMM authors who write about listening to patients are countering the

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[11] Arnold Wagner, A Piece of My Mind, "Listen to the Picture," *JAMA* 259, no. 3 (January 15, 1988): 420.

[12] Ibid.

clinical requirement to change the patient's story into medical vocabulary, allowing the patient's words to inform their understanding of the patient's symptoms as well.

Thus far the APOMM writers describe taking time to listen more, and paying close attention to the words patients use to explain their circumstances, as ways to enhance their perception of patients. One APOMM author, in a column entitled "A Crowded Room," shows another way to fortify his listening skills by using his imagination.[13] Dr. David Hatem expands doctors' understanding of the clinical encounter in his story from 1997. He writes about a patient, likening her extensive medical history and clinical complaints to a bag that also contains (figuratively) "people" she brings along to her appointment.[14] Dr. Hatem astutely acknowledges the other people who have come with the patient each time she mentions a family member, pulling them from the imaginary bag, along with her physical complaints.[15] The patient discusses her husband, her daughter, the daughter's baby, and her sister. Dr. Hatem describes his awareness of the influence of each of these family members on the patient's situation. He explains that once the visit is over the patient "gathered her belongings, her loved ones, her concerns. She escorted them out of the room and took them all home with her."[16] The author gives his readers a different way of looking at a patient's family history. Instead of reviewing a list of diseases in family members, he makes each person come alive in a way that allows

[13] David S. Hatem, A Piece of My Mind, "A Crowded Room," *JAMA* 277, no 17 (May 7, 1997): 1350.

[14] Ibid.

[15] Ibid.

[16] Ibid.

him to appreciate and speculate about their influence on the patient's illness. Dr. Hatem gains an understanding of his patient with his curiosity and creativity.

In his story about one patient, Dr. Hatem incorporates his thoughts on medical practice, summarizing in his closing paragraph,

> The room had seemed too small today for all she had brought with her, and all the reasons she needed to bring them along. The visit started with only neck pain and a lump on her thigh. There are no builders or clinic planners who could understand what had taken place today, or give me a room large enough. But it is not their job to understand this. It is our job to help carry the bag, to help reorder its contents, and sometimes to help the people for whom we care to discard some of the heavier contents of life's bag. We live and work in many crowded rooms and I only hope that I can take the time to notice and greet everyone who is there.[17]

The doctor's artful approach yields enlightenment about factors that affect patient responses to illness and treatment. Patients step out of their routine lives to visit the doctor, returning to everything and everyone they leave behind (or in the case of Dr. Hatem's patient, sometimes bring with them) when they go to the doctor. The visit is a moment in time that passes, when the doctor's challenge is to listen and understand as much as possible in that pause, before the patient leaves and the doctor goes on to the patient story in the next room.

This section about listening to patients is about the art of listening, versus the science of hearing. The ability to hear *and* listen is one way the art and science of medicine are manifest in encounters between patients and doctors. In an article about hearing versus listening in daily life, Seth Horowitz makes observations applicable to the physicians writing in APOMM about the importance of listening to patients. He writes,

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[17] David S. Hatem, A Piece of My Mind, "A Crowded Room," *JAMA* 277, no 17 (May 7, 1997): 1350.

> Listening is a skill that we're in danger of losing in a world of digital distraction and information overload. . . "You never listen" is not just the complaint of a problematic relationship, it has also become an epidemic in a world that is exchanging convenience for content, speed for meaning. The richness of life doesn't lie in the loudness and the beat, but in the timbres and the variations that you can discern if you simply pay attention.[18]

In the three columns referenced in this section, APOMM authors provide the readership with approaches to patients they may not have considered, experienced or imagined. These are: listen sensitively, listen carefully, listen creatively. The unique contribution of APOMM to the writing about patient-physician relationships is exemplified in the variety of these three examples, by different authors writing about the same subject – the importance of doctors learning how to listen, and understand their patients.

Spending Time With Patients

While creative listening is the subject of some columns, other columns are about making time, or capturing whatever time is available to listen to patients. Even though the time they have may differ, the APOMM writers want readers to know how they manage to create relationships with their patients no matter the circumstance. Dr. Elizabeth Toll is a primary care physician writing in 2015 about her decision to change her weekly schedule to include one morning of counseling patients, rather than continuing with what she calls "the daily reality of managing scores of patients, legions of medications, and

[18] Seth S. Horowitz, Sunday Review, "The Science and Art of Listening," *The New York Times*, November 9, 2012, accessed February 12, 2017, http://www.nytimes.com/2012/11/11/opinion/sunday/why-listening-is-so-much-more-than-hearing.html.

endless administrative hassles. . .”[19] Dr Toll wants to spend more time with patients in the busy environment of her practice. She uses her column to explain that she feels better able to treat patients she knows well, saying, “The longer, quieter visits are treasured oases in the technological and multitasking world of modern medicine.”[20] The reader may recall Dr. Squier (referenced in Chapter One) who turns to the physical activity of haying to relieve her professional fatigue, while Dr. Toll allows herself more time with patients to increase her professional satisfaction.

As she shares what fortifies her practice, Dr. Toll makes an observation about standard medical approaches to patients: “For all the time we spend inquiring about symptoms of illness and discomfort and offering anxiety-provoking anticipatory guidance about potential disasters, physicians never learn to ask patients what makes them feel well, nor to develop techniques to help patients tap into their own healing powers.”[21] The focus of medicine is almost exclusively on what is wrong and Dr. Toll reminds readers that patients have reservoirs of interests, hobbies and talents that can contribute to wellness. This may be something healthcare professionals do not often consider, trained to quickly ascertain what is wrong in order to begin fixing problems. Dr. Toll thus contributes another approach to perceiving patients for doctors. She encourages them to take time to think more broadly about illness by becoming curious about what helps patients feel good, and by carefully listening to the answers they get.

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[19] Elizabeth Toll, A Piece of My Mind, “Back to the Heart of the Matter,” *JAMA* 313, no. 18 (May 12, 2015): 1829.

[20] Ibid.

[21] Ibid., 1830.

Dr. Toll spreads the word to her colleagues about a change that brings her personal and professional satisfaction and expands her clinical role. She crafts an arrangement that works for her, but her column raises the question of how practical this approach is for other doctors interested in modeling her decision. The demands of various private, group and institutional healthcare settings may not make such arrangements viable for other doctors desiring similar customization.

Relationships, however, are not entirely a function of the amount of time patients spend with their doctors. Meaningful relationships can form even with little time for communication. Two doctors write in APOMM about the limits of time in the operating room, and the effect on patient relationships. A urologic surgeon, Dr. R. Stephen Hillis, explains interactions with patients from the perspective of the brief time he shares with them, often while they receive local rather than general anesthesia and are hence awake while he operates. He writes in 1986:

> I have observed that the stress of a surgical procedure, however minor, and the unique relationship between surgeon and patient provide an environment for conversation that brings out emotions and philosophies heretofore suppressed by inhibitions. I know a patient better after half an hour in the operating room than after months of a more formal relationship.[22]

The author then recounts a story told by one of his patients during a procedure, preserving it as an example of what he appreciates in his relationships with them.

The operative environment, in addition to limiting the time patients and doctors spend in conversation, introduces unique unpredictability into the patient-physician relationship. Despite safety checks and procedures, surgical outcomes involve a degree of risk and uncertainty. Uneventful surgeries and procedures can diminish recognition of the extraordinary feat of successful anesthesia. Anesthesiologists accompany patients on

[22] R. Stephen Hillis, A Piece of My Mind, "Joe," *JAMA* 255, no. 12 (March 28, 1986): 1565.

journeys into unconsciousness, safely administering anesthetic agents, constantly monitoring the patient's response to sedation and the procedure, reversing anesthesia and restoring the patient to consciousness whenever possible. The next APOMM story exemplifies this special relationship.

Distinct features of the patient-anesthesiologist relationship are unique in medicine. After an often-brief pre-operative conversation followed by post-operative monitoring, typically the interaction between patient and physician ends. Anesthesiologist Dr. Robert Johnstone writes about a particular part of his role over a thirty-four year career, in 2006. That is, each time he administers anesthesia to patients, he knows a certain number will not awaken owing to their illnesses, injuries or intra-operative complications. Some patients will be unresponsive post-operatively, and others will die later. Dr. Johnstone's column is entitled "Last Words," and he writes about how he converses with patients while preparing to administer anesthesia, asking questions and explaining what he will do.[23] He shares his rationale:

> Few plan their last words. They usually speak them unknowingly. And I hope I'm not hearing them. I've learned to say some appropriate lines of explanation and comfort for tracheal intubations though, and then to pause. Patients usually respond, "Thank you." If they survive nothing is lost, if they die something is gained. The light of their final gratitude can shine on memories of them forever.[24]

Dr. Johnstone's words elicit the response he desires, should the patient not awaken. This type of interaction with the patient serves two purposes; the first is to comfort the patient in the pre-operative setting, the second is to comfort the patient's family should the anesthesiologist need to convey the patient's last words. This doctor

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[23] Robert E. Johnstone, A Piece of My Mind, "Last Words," *JAMA* 295, no. 14 (April 12, 2006): 1624.

[24] Ibid.

consciously steers the conversation for everyone's benefit, believing that he, the patient, and the family gain some peace of mind.

These two APOMM columns demonstrate that a great amount of time is not always the most essential feature of a rewarding patient-physician relationship. Listening is at the center of the relationships described thus far, and the APOMM columns offer strategies to doctors interested in learning more about how to listen to patients.

The Scope of Relationships With Patients

The preceding stories concern patients who are able to communicate with their doctors. Doctors and nurses are trained to ask many questions of the patient to establish a diagnosis or at least a differential diagnosis of the most likely causes of illness. What happens when the patient cannot communicate? There are other ways to learn about patients. One column from a doctor whose patient cannot speak due to dementia is about alternative ways of communicating, and gaining insight. In 2008 Dr. Stewart Babbott writes that as he examines the patient, she holds his hands with alternating pressure. He writes, "While not oriented to person, date, place, or time, we had become acquainted in silence. I asked questions with my presence, my examination, and she answered in her way. This was the connection I was seeking, not what I had expected, and surprisingly in silence."[25] The doctor expands the conventional definition of listening for his readers with his story about a nonverbal patient. He explains the unexpected connection he feels from only eye contact and touch, opening the possibility of the same to APOMM readers.

[25] Stewart Babbott, A Piece of My Mind, "Touched," *JAMA* 299, no. 24 (June 25, 2008): 2834.

Other APOMM columns also demonstrate the breadth of what constitutes relationship in medicine, and the depth of commitment to patient relationships on the part of caring physicians. One doctor writes thirteen years after the fact about his experience in 2001 when, as a medical student in Manhattan, he is sent to work in the morgue at the medical examiner's office, cataloging remains of the victims at the World Trade Center.[26] On other days, he continues his work in the hospital. These contrasting assignments shape his perspective on the patient-physician relationship. Dr. Jesse Raiten writes:

> [O]ur success as physicians is only as good as our ability to appreciate and adapt to the individual needs of our patients. To recognize that while the human body is largely the same among people, each piece of flesh pulled from the rubble of the World Trade Center told its own story, held its own clues, and would follow its own path before being met with an inimitable response from the patient's family.[27]

In recalling a terrible and unusual experience while a medical student, Dr. Raiten refers to the remains of people he carefully records as patients. This is an example of a relationship without even the presence of the human form. The medical student's patients are anonymous (until possible identification), yet he perceives connection to them from his responsibility to care for their remains.

The combination of Dr. Raiten's medical training with his work in a catastrophic "clinical" setting seems to contribute to a personal philosophy about the importance of understanding patients that he shares with his colleagues. He believes,

> Medical school teaches us about the cure, but experience teaches us how to achieve it. . . Experience teaches us to recognize what really matters to people, to sift through the routine and the remarkable, to separate the trivial from the true essence of a patient's needs. To recognize that to best serve our patients we must

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[26] Jesse Michael Raiten, A Piece of My Mind, "The Language of Experience," *JAMA* 312, no. 10 (September 10, 2014): 1001.

[27] Ibid.

> adapt to them, to learn to see things through their eyes, to work on their terms. Medical school teaches us to speak the universal language of medicine, but our patients teach us to understand it.[28]

Dr. Raiten writes about gaining a better understanding of medicine from his relationships with patients. Even in dire circumstances, he establishes what he perceives as professional relationships to patients, influenced by his philosophy of medicine, as an expression of the medical humanities.

The columns enforce the importance of relationship in medicine, from writers explaining the range of interaction possible between people who happen to be patients and the physicians caring for them. To that end, many of the APOMM authors write about the desire to practice art in their caregiving, by recounting special moments with patients that contribute to their professional satisfaction and purpose.

Dr. Ram Gordon writes about a patient experience in 2010, five years after the fact, remembering clearly the bond he felt with a man who regularly wrote him notes of thanks, and reflecting on their appointments together.[29] Dr. Gordon is deeply affected by the patient's death many months later. While struggling with his emotions he writes, "Ultimately, I found peace in the realization that medicine is an art and that interpersonal relationships are at its core."[30] In this story, the nature of the patient-physician relationship includes confirmation from the patient that the doctor is helping. The doctor listens to the message in the patient's words, knowing he has helped the patient and explaining how much the patient helped him. Dr. Gordon is a new practitioner at the time,

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[28] Jesse Michael Raiten, A Piece of My Mind, "The Language of Experience," *JAMA* 312, no. 10 (September 10, 2014): 1001.

[29] Ram Y. Gordon, A Piece of My Mind, "With Appreciation," *JAMA* 303, no. 18 (May 12, 2010): 1790-91.

[30] Ibid., 1791.

trying to maintain professional demeanor; he is enriched professionally and personally when he overcomes his reticence and allows himself to befriend the patient as well.[31] He experiences the satisfaction of blending scientific and interpersonal understanding, and immortalizes the patient in his column, for himself and his readers.

The APOMM columns in this section advise readers in skills to enhance the physician's understanding of the patient, and about how such skill results in personal and professional enrichment for the doctors. One hopes that such enrichment returns to the patient in the form of humane care (as described in the story above), but since doctors tell the APOMM stories, often only their impressions and opinions are expressed to readers. They write about the rewards of relationships with patients through understanding, listening, and an awareness that patients and physicians share the human condition.

Patients, Physicians and the Shared Human Condition

In the clinical setting, the APOMM physicians are reminded regularly that what separates them from their patients is a single unexpected laboratory result, a complicated pregnancy, a sick child, an accident. Life changes abruptly for people who become patients. Dr. Lawrence Koplin writes about a patient experience early in his career that remains with him, observing in 1985, "one of the great gifts of being a physician lies in the daily reminder of our own fragility, that the only difference between physician and patient is often quite simply, 'bad luck.' "[32] The author learns from the patient that life

[31] Ram Y. Gordon, A Piece of My Mind, "With Appreciation," *JAMA* 303, no. 18 (May 12, 2010): 1790-91.

[32] Lawrence M. Koplin, A Piece of My Mind, "The Board Case," *JAMA* 254, no.21 (December 6, 1985): 3094.

and medicine are about "people helping other people, one day at a time."[33] Dr. Koplin expresses gratitude to his patients, as do many of his fellow authors, for similar lessons they may unknowingly impart to their physicians.

APOMM authors practicing in communities where they live describe another form of close patient-physician relationships. Their physical proximity to patients fosters emotional closeness and professional satisfaction. One wistful piece comes from Dr. Richard Ohmart, reflecting nostalgically on his career after attending the wedding of two young people he has known since birth in their western Kansas farm community. As he considers why the wedding stirs great sentiment in him, he observes about his life and medical practice "I am doing what I dreamed of and trained for, what I enjoy most, helping my friends when they need me, and accepting their help when I need them."[34] While Dr. Ohmart's column is primarily an ode to his Kansas home and heritage, it is also the understated story of someone content with his profession and grateful for the entwining of his life and work. He considers the care he gives to his neighbors as their doctor, recognizing that people need each other to survive, but makes no distinction between the value of any one person's contribution relative to another's.[35] Dr. Ohmart's identity as a physician sounds inseparable from his identity as a friend and neighbor, and for him patient-physician relationships are one facet of his relationships with the people in his community.

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[33] Lawrence M. Koplin, A Piece of My Mind, "The Board Case," *JAMA* 254, no.21 (December 6, 1985): 3094.

[34] Richard V. Ohmart, A Piece of My Mind, "Prairie Wedding," *JAMA* 261, no. 4 (January 27, 1989): 616.

[35] Ibid.

Similarly, Dr. David Loxterkamp writes in 1999 about what he believes is immutable in the relationships physicians must create and maintain with their patients, observing,

> I reaffirm that relationships are the bedrock of medical practice. . . [I] am moored to my patients' predicament, their fleshed-in lives, and the unflinching fact that we are interchangeable. Commoners all. Located by the real things we live by.[36]

This is one doctor's succinct, philosophical and social treatise on the practice of medicine, and another example of the medical humanities expressed in the APOMM columns. His interpretation of a satisfying patient-physician relationship sounds interchangeable with the definition of a good neighbor. He and his neighbors live together, helping each other in whatever way they can. Rather than feeling his contribution makes him somehow different from his patients, he considers what he gains from them equivalent to what he gives as their doctor.

Dr. Loxterkamp (in a second column, from 2010) describes medicine as a calling,

> As physicians, we are chosen to witness the destruction wreaked by illness and age. Our challenge is to see the patient who has lost sight of himself. Thus, we are called to live where we serve, anchored against the currents of geographic mobility and "professional distance." How else can we relocate those who have been dislodged from their identity? What we gain is an appreciation for ordinary lives that reawaken in quiet conversation, over a cup of tea, as we sit like sentinels beside them. These are ordinary lives like our own. Twenty-five years of living in community has taught me that our differences empty into an indifferent sea where death inevitably finds us, but it cannot defeat the will to endure.[37]

The doctor writes from the experience of living where his patients live, as partners in all that is necessary for communities to function and thrive. But his words are

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[36] David Loxterkamp, A Piece of My Mind, "Facing Our Mortality; The Virtue of a Common Life," *JAMA* 282, no. 10 (September 8, 1999): 924.

[37] David A. Loxterkamp, A Piece of My Mind, "Old Men and the Sea," *JAMA* 304, no. 1 (July 7, 2010): 19.

metaphorical as well. Dr. Loxterkamp encourages physicians to understand the importance of getting past professional demands (science) to know patients (art) in order to establish a therapeutic bond; he suggests physicians can embrace the concept of communing with their patients, even if not in literal terms, bringing another perspective to the patient-physician relationship. (Dr. Loxterkamp is featured in a PBS documentary called "The Quiet Revolution" that originally aired in April 2015. The film is about healthcare professionals interacting with patients in personalized ways, in community settings. Dr. Loxterkamp expounds on his APOMM writings about the importance of community, and is seen interacting with his patients, colleagues and neighbors in Belfast, Maine. The film can be accessed at: http://www.pbs.org/program/rx-quiet-revolution/).

While not all physicians live in the communities where they practice, as in the cases of Drs. Ohmart and Loxterkamp, there are other ways physicians can feel connected to patients. These involve using one's imagination to understand patients and patient circumstance. Perceiving the lives of patients is another skill doctors can use with the goal of providing sensitive care. Some examples of creative understanding are described in the next section.

Unique Physician Perspective on Relationships With Patients

One of the features of the APOMM columns is the ability of some authors to describe moments in medicine in unique ways. Doctors train to learn observation and investigative skills; when such skills are applied to their non-clinical writing, interesting thoughts and perspectives on patient care can emerge. Such thoughts give new meaning to the title of the *JAMA* columns. "A Piece of My Mind" is just that; the physician-writers

give a piece of their minds, meaning a perspective or perception, to the readership. Certain columns include imaginative descriptions of the patient-physician relationship.

The APOMM authors write about the importance of understanding patients as fully and completely as possible. Dr. Michael Radetsky writes a column in 1985 entitled "Sudden Intimacies," a title capturing the essence of the patient-physician relationship. Dr. Radetsky believes,

> No, for me fulfillment comes from the sudden intimacies with total strangers – those moments when the human barrier cracks open to reveal what is most secret and inarticulate. A word can betray the deepest emotion. A look can reflect a world of feeling. Illness strips away superficiality to reveal reality in etched detail. This revelation can fuse together disparate lives in unexpected kinship.[38]

For this doctor the relationship he feels with the patient comes when the veil between them is figuratively removed. The relationship is defined by the "kinship" he feels with his patients.[39] The focus and clarity with which Dr. Radetsky sees his patients is similar to that in the peri-operative conversations recounted by Drs. Hillis and Johnstone. Learning about patients defines a satisfactory relationship for the doctors, producing rapport and closeness, considered by the writers as confirmation of their practice.

There are other ways of exploring the literal and symbolic space between patients and doctors vis-à-vis therapeutic relationship. Dr. Nir Lipsman, describes his feelings each time he pushes the curtain away to approach a patient, removing what separates them physically. His APOMM column from 2009 is entitled "Curtains," and all but the

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[38] Michael Radetsky, A Piece of My Mind, "Sudden Intimacies," *JAMA* 254, no. 10 (September 13, 1985): 1361.

[39] Ibid.

last paragraph of the piece begin with "Pulling the curtains aside. . ."[40] Some of Dr. Lipsman's paragraphs start as follows: " 'Pulling the curtains aside, I was taken aback,' and 'Pulling the curtain aside, I saw three people around the patient, but felt the presence of more.,' and 'Pulling the curtains aside I saw a familiar face.,' and 'Pulling the curtains aside, I saw a family huddled around a stretcher.' "[41] Dr. Lipsman demonstrates his awareness of entry into relationships with patients and their families in the symbolism of opening the curtain. He writes,

> Pulling the curtains aside is an intensely personal moment, one that implies permission to probe the most intimate details of patients' lives. . . They are artificial but, for physicians, very real boundaries between physician and patient that once pulled aside, invite us, and all of our emotional baggage, biases, preconceptions, and prejudices, into the lives of a stranger.[42]

The column stems from Dr. Lipsman's struggle to see all of the patients who wait for him during a very busy night in the emergency department. But his message about the importance of respecting his shared moments with patients teaches readers that even in the midst of professional demands, and while acknowledging their individual perspectives, they can create a space to understand the needs of the patients who trust in them.

The imagery of the curtain can symbolize other barriers between patients and doctors that must be overcome to allow the start of a relationship, no matter how brief or lengthy. Dr. Lipsman describes his brief moment of acute awareness when he pulls each curtain, and this is the moment of communing with patients he describes to his colleagues,

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[40] Nir Lipsman, A Piece of My Mind, "Curtains," *JAMA* 302, no. 17 (November 4, 2009): 1845.

[41] Ibid.

[42] Ibid.

reminding them of the solemn privilege they exercise when they enter the patient's space.[43]

The clinical encounter is a dialogue between two people, arguably sacred in its personal and intimate nature. The patient, like a congregant, enters the confessional that is the clinical care setting, divulging symptoms, behaviors, choices, sometimes in hushed voice, that affect health and prognosis. The doctor, like the cleric, issues good or bad news, a plan of action, and advice about how to live, while shielded by professional demeanor and while withholding judgment. Dr. Donald Berwick, addressing his comments to graduating medical students, writes, "The career you've chosen is going to give you many moments of poetry. My favorite is the moment when the door closes - the click of the catch that leaves you and the patient together in the privacy - the sanctity - of the helping relationship."[44]

Doctors examining the intricacies of their relationships with patients in APOMM focus on the communion between two people in therapeutic relationships. In 1997, Dr. David Mumford shares a story about what he learns from a hospitalized patient dying from melanoma during their visits. He writes, "we both looked forward to conversational evenings discussing life, religion, science, the healing power of humor combined with country music . . ."[45] The patient shares that he is reconciled to dying, and the doctor shares the effect of those words on his understanding of the patient-physician relationship. Dr. Mumford closes his column as follows,

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[43] Nir Lipsman, A Piece of My Mind, "Curtains," *JAMA* 302, no. 17 (November 4, 2009): 1845.

[44] Donald M. Berwick, A Piece of My Mind, "To Isaiah," *JAMA* 307, no. 24 (June 27, 2012): 2597.

[45] David M. Mumford, A Piece of My Mind, "Thank God I Have Cancer," *JAMA* 278, no. 11 (September 17, 1997): 956.

> He [the patient] paused a moment and explained. "Without this extra time, I never would have known what love and tenderness are possible between people on this earth." I knew a profound new question challenged me: Is love the essential marrow of our humanness? I also realized an unknown door in the human spirit – one I could never glimpse through scientific reasoning – had opened to me. Suffering, however difficult, can be a wise parent to personal meaning. One person's verities may unexpectedly differ from another's. And, more enduringly, demonstrations of wisdom and grace by patients can reverberate endlessly in caregivers. Certainly that happened to me.[46]

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The APOMM stories about factors that enhance patient-physician relationships show a range of writing. The doctors use varied and creative approaches to focus on what they learn in their exchanges with patients, offering readers an abundance of stories to enrich their own practices, and their comprehension of the humanities in medicine. The authors maintain that listening to patients, using a variety of techniques to understand patients, and acknowledging that little separates patients from physicians as fellow members of the human collective, are central to medical care. To that end the APOMM physician-writers give students and practitioners both practical and imaginative observations and opinions about working with patients. As a trove of stories about the intricacies of human behavior and interaction in patient-physician relationships, the columns expand reader understanding of the humanities as they pertain to medicine.

Despite the continual changes to medical education, medical care models, allocation of resources, reimbursement of costs and political and social influences on healthcare, the APOMM physician-writers regularly argue the importance and value of thoughtfully establishing relationships with their patients, over the thirty-six years of

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[46] David M. Mumford, A Piece of My Mind, "Thank God I Have Cancer," *JAMA* 278, no. 11 (September 17, 1997): 956.

columns reviewed. The doctors explain their professional and personal enlightenment from such encounters, in lessons they learn from their patients about how to understand and appreciate the detailed stories of people who need care.

Conversely, other APOMM authors address factors that may diminish patient-physician relationships in the next chapter. These include socioeconomics, race, medical error and business influences on clinical care.

CHAPTER THREE

FACTORS THAT DIMINISH THE PATIENT-PHYSICIAN RELATIONSHIP

This chapter is about how APOMM authors perceive factors that diminish patient-physician relationships, often resulting in feelings of emotional and professional dissatisfaction. Unlike the preceding chapter, this chapter addresses factors that may prevent or impair relationships between patients and physicians. Topics include social influences (socioeconomics and race), personal perception of errors in medical judgment, public accusations of medical error (malpractice allegations), and the impact of the business model in modern healthcare on patient-physician relationships. Approximately fifty columns published between 1981 and 2016 were considered for this chapter, and the thirty-two columns chosen illuminate each topic. The columns in this chapter speak to the desire of APOMM physician-writers to address impediments to their professional relationships with patients.

The writing challenges readers to consider the implications of socioeconomics and race (in stories about access to care), philosophy and ethics (in stories about medical error) and cultural changes in medical practice (for purposes of this discussion the expansion of business models in caregiving is considered a cultural influence). These elements of the humanities as they pertain to medicine infuse the APOMM stories about patient-physician relationships.

Socioeconomics and Patient Relationships

The physician-writers in APOMM sometimes share emotional responses to the conditions where they work, particularly in impoverished communities. The writing

draws attention to situations where providing medical care is challenging and demanding in ways that differ from resource-rich clinical environments. One physician describes one shift in a pediatric emergency room in the Bronx, NY, where caring for patients without adequate shelter or utilities is "an exhausting and frustrating task."[1] Dr. Robert Marion's column from 1987 centers on how to improve patient health under circumstances that often preclude ongoing patient-physician relationships. His story is about an eleven-year-old girl pregnant from the sexual assault of an older brother. After the complicated and lengthy visit Dr. Marion writes, "I gave [the patient's mother] my home phone number in case she needed to talk, knowing she'd never use it. . . Saying goodbye, I doubted if I'd ever see any of them again."[2] The doctor faces not only the implications of the pregnancy for his pediatric patient, but the implications of her social and economic circumstances on her health as well. Dr. Marion contemplates the plights of his patients, allowing himself some time to process the events of the day, and then returns to the work at hand.[3]

Whether columns prompt APOMM readers to think about the author's circumstance, or compare the author's situation to their own medical practices and concerns, is unknown. Some APOMM writers may seek intellectual or emotional acknowledgement or understanding from readers. In that spirit, a story from Dr. Charles Saunders comes in a jarring column about an infant bitten by rats while living with eight

[1] Robert W. Marion, A Piece of My Mind, "A Dip in the Pool," *JAMA* 258, no. 15 (October 16, 1987): 2116.

[2] Ibid.

[3] Ibid.

other people in an uninhabitable building.[4] Dr. Saunders uses APOMM for his social commentary, writing in 1986:

> The pathogen in this case was that which brings together nine people in a small room in a dilapidated, condemned building. It was that which perpetuates ignorance, stimulates crime and aggression, and spawns poor hygiene and nutrition. It lends itself to ill health from poor host defenses before a plethora of bodily insults, including bountiful introductions to communicable diseases, exposure to environmental hazards, encouragement of destructive vices, and encounters with violence – all with the most limited access to health care. The pathogen was poverty. In a science and a profession whose mission is the elimination of disease and the alleviation of suffering, what antimicrobial, what surgical procedure, what pharmacologic agent do we possess for that pathogen?[5]

The column provokes an almost visceral reaction, and also leaves readers without any solution to the health problems stemming from poor socioeconomic status. People lacking resources and opportunities in daily life are patients in some of the APOMM stories. Their circumstances dictate often infrequent and irregular forays into the health-care system, diminishing their chances of developing lasting relationships with doctors. Dr. Saunders asks his readers to consider his challenge, and examine their own thoughts about the humanitarian efforts of physicians trying to help patients in impoverished circumstances.

In 2014, medical student Komal Kothari writes about her education in social medicine just as she is beginning to interact with patients, and why such knowledge is essential for her future practice. She writes,

> Just as we study pathophysiology to diagnose illness, so too we must study social medicine to recognize the symptomatology associated with iterative social processes. Through social medicine, I have gained insight into some of the salient themes that underlie every patient's illness – financial resources, social support,

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[4] Charles E. Saunders, A Piece of my Mind, "The Most Serious Pathogen," *JAMA* 256, no. 2 (July 11, 1986): 260.

[5] Ibid.

> race/ethnicity, educational background, external stressors, and cultural views. And I have learned that within the health system, resource availability, structure of care delivery, mores of medicine, and beliefs of health professionals are dynamic forces that have an impact on patients' trajectories through a course of illness. For a physician, understanding the wide spectrum of social factors and health care experiences that affect patients' well-being can provide a new approach for recognizing an individual patient's context and delivering more valuable care.[6]

Kothari's use of the phrase "recognizing an individual patient's context" is another way of describing an understanding of the patient's story.[7] She learns the importance of factors representing the humanities as they apply to medicine. It would be interesting to know whether Drs. Saunders' or Marion's columns are used in Kothari's social medicine studies. Both writers sound weary. Kothari, as a student, is just learning how to develop and maintain relationships with patients by appreciating the many components of what constitutes health and illness in each person, echoing the "biopsychosocial model"[8] of medicine advanced by Dr. George Engel in 1977. She sounds energetic in her professional development and mission. These three APOMM columns demonstrate the ongoing efforts of physician-writers over thirty years to understand and explain the sometimes-daunting effect of socioeconomics on health, and relationships with patients. The doctors telling patient stories in the setting of limited socioeconomic resources appreciate the risks not only to relationships with their patients, but also to their professional satisfaction.

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[6] Komal Kothari, A Piece of My Mind, "The Case for Social Medicine," *JAMA* 311, no. 24 (June 25, 2014): 2484.

[7] Ibid.

[8] George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (April 8, 1977): 132.

Racial Influences on Patient-Physician Relationships

The race of the patient receiving medical care is a factor in the diagnosis of certain race-related conditions and diseases, but should not influence access to, or quality of care. The race of the physician similarly should not determine access to patients or ability to provide care. But race influences personal behavior in medicine just as it does behavior in general society. Stories from APOMM physician-writers relate instances when race is as much the focus of the patient-physician relationship as any diagnosis they make or treatment they administer.

Race relations are a constant societal reality and challenge, and the presence of racial bias in the delivery of healthcare is disturbing. Reports about limitations on access to care, especially for patients of color, appear in both the lay press and professional journals. Such articles are often patient-focused. The APOMM authors share stories about race as a barrier to quality medical care for both giver and receiver, offering *JAMA* readers a different perspective on race from articles found elsewhere. While the physician-writers in APOMM offer perspectives on how racial attitudes affect individual patient-physician relationships as a starting point, they also tell about the effects of racial attitudes on professional practice.

Productive relationships between patients and physicians result, in part, from open communication between mutually racially sensitive and respectful persons. Two medical students, published in APOMM ten years apart, tell of their racially influenced encounters with patients. A white student writing in 1987 touches peripherally on his black patient's physical health issues, but writes deeply about the psychological distress of the man who has lived with bigotry in a small Alabama town. W. Blake Rogers, a first-

year student, is angered by what he sees while working in a clinic. He recalls growing up in the South, assuming he has seen the spectrum of racism.[9] But his experience in Alabama causes him to write, "I'd never seen anything like the horrid, vicious face that racism wore in that little town."[10] Rogers writes of the tentative steps he and the patient take towards each other metaphorically during their conversation, and how he is overwhelmed when at the end of the visit the patient thanks the visiting student for speaking with him.[11] Rogers creates a brief, positive encounter with the patient, and is enlightened by his interaction with the man.

Courtesy and respect are therapeutic for patients. While medical or surgical attention are necessary in caregiving, attention to individual patient circumstance and need is also essential. In 1997, white medical student Ann Dominguez describes a black patient whose chief complaint when questioned is "injustice."[12] He shares his health history linked to the racism he has experienced during his life. Dominguez feels ill equipped to offer him any solutions to the social and ethical problems he discloses to her.[13] But as she engages him in conversation, closely listening to him and following his lead, she learns that he believes his faith has sustained him. She also is a person of faith and offers to pray with him.[14] He is surprised and pleased, accepts her invitation and they pray together. She is unable to treat the social illness he describes with medicine or

[9] W. Blake Rogers, A Piece of My Mind, "Next Patient," *JAMA* 258, no. 1 (July 3, 1987): 96.

[10] Ibid.

[11] Ibid.

[12] Ann E. Dominguez, A Piece of My Mind, "The Chief Complaint," *JAMA* 278, no. 1 (July 2, 1997): 4.

[13] Ibid.

[14] Ibid.

procedures, instead providing spiritual solace because she is keenly aware of her responsibility to help the patient in some way. She applies her interpretation of one element of the humanities (in this case her religious beliefs) to her clinical work. Dominguez establishes a relationship with the patient by honoring his faith and sharing her own. She, like Rogers, sounds determined to provide the patient with an encounter different from his past negative experiences in healthcare settings, and administers her treatment. Both students voice earnestness in their efforts to do what they can for their patients.

The preceding stories concern non-black medical students who want to help their black patients. A different perspective comes from the APOMM voice of Dr. Pius Kamau, a black doctor writing in 1999 about his first experience with a white skinhead patient with a swastika tattoo. Dr. Kamau writes revealingly, "Confronted with declared and naked hate, I wondered what were my obligations both to him and to myself."[15] The patient refuses to look at or speak to the doctor during his hospitalization. The column is about the author's challenge to treat the patient in a way that meets his professional standards. He says, "Yet without the expected give-and-take and mutual respect and trust so crucial to the traditional patient-physician relationship, how could I take care of the whole person?"[16]

Contemplation of the clinical situation described above raises questions within the context of humanity in medicine as expressed in the patient-physician relationship. Dr. Kamau ponders his obligation to the patient in a question to his readers. He does not

[15] Pius K. Kamau, A Piece of My Mind, "A Case of Mutual Distrust," *JAMA* 282, no. 5 (August 4, 1999): 410.

[16] Ibid.

refuse to give care, but wonders how to provide it and how much to give. How does someone fearful of a patient provide care? What can the quality of that care be? Personal philosophy and professional ethics may compete in the mind of a physician trying to decide what to do. Medical students are taught the need for objectivity in their dealings with patients, while being encouraged to communicate with care and sensitivity at the same time. This approach, intended as the synchronized science and art of medicine, is challenging under ideal conditions, but especially so if physicians fear for their physical safety in caregiving settings. In his personal story, Dr. Kamau addresses the fear other doctors may feel trying to administer care guided by their medical training and the humanities under equally difficult clinical circumstances.

Concern about how best to provide care in challenging settings is a recurring theme in the APOMM columns about race. Dr. L.Stewart Massad writes as an oncologist practicing in Chicago, treating many African-American patients; he is not of the same race. He explains his African-American patients may distrust traditional medical settings, which often delays their visits to doctors until symptoms are serious and prognoses are poor.[17] Dr. Massad understands his patients' reticence to seek help when they share their past experiences with him. In 2000, he writes,

> Older African Americans have recalled for me the days when they were barred from community and university hospitals or segregated to wards with few amenities. Physicians' claims to benevolence and objectivity were deeply wounded by the Tuskeegee experiments of the mid-century. Less often cited, perhaps because the practice continues, has been the segregation of patients in academic medical centers according to their insurance status: private patients are managed by skilled attending physicians, while uninsured patients, disproportionately African American, have been treated and operated on by residents in training, too often with suboptimal supervision. Even minority

[17] L. Stewart Massad, A Piece of My Mind, "Missed Connections," *JAMA* 284, no. 4 (July 26, 2000): 409-10.

patients who lack medical sophistication understand this difference.[18]

Dr. Massad puts effort into dispelling distrust by carefully building relationships with his patients. He employs listening skills, shows respect, demonstrates humility, appreciates the value of alternative therapies, and reinforces that while he is practicing in a teaching hospital where residents participate in treatment, he will oversee his patients' care.[19] This doctor recognizes the need for a relationship with patients perhaps reticent of treatment, writing, "With work, we establish the human connection that permits us together to do the work of healing."[20]

Thus far the APOMM stories cited involve negative influences on relationships between patients and physicians of different race. Yet other APOMM authors reveal that shared race does not necessarily guarantee positive patient-physician relationships. One APOMM author writes of an initially negative start to an ultimately positive interaction with a patient. Dr. Damon Tweedy, in a 2012 column, shares his experience as a black psychiatry resident assigned to a black woman patient who does not want to see him professionally because of her fear of black men.[21] The author writes about the experience of changing his attitude towards a patient. Neither resident nor patient wishes to embark on a clinical relationship. Yet the resident is encouraged to see the patient by his supervisor, and the patient is encouraged to see the doctor by her friend; it sounds as

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[18] L. Stewart Massad, A Piece of My Mind, "Missed Connections," *JAMA* 284, no. 4 (July 26, 2000): 410.

[19] Ibid.

[20] Ibid.

[21] Damon S. Tweedy, A Piece of My Mind, "A Perfect Match," *JAMA* 307, no. 7 (February 15, 2012): 673.

though the eventual outcome is mutually satisfying.[22] At the beginning, Dr. Tweedy explains, "So there we sat, fearful patient and frustrated physician, both of us with deep reservations about where this clinical venture would lead."[23] Dr. Tweedy tells how his approach to psychotherapy changes from working with the patient:

> I had entered psychiatry with a biomedical slant, dubious toward and often embarrassed by those who were strident psychotherapy advocates. But I am certain that no medication could have altered Diane's outlook on race the way our sessions did. And for the first time, I witnessed the unique benefits that racial concordance can have in a clinic setting.[24]

The doctor believes the race he shares with his patient eventually bolsters their relationship. The psychosocial effect of shared race becomes a potential adjunct to the doctor's standard treatment repertoire. (Dr. Tweedy is the author of *Black Man in a White Coat: A Doctor's Reflections on Race and Medicine*, a New York Times bestseller released in September 2015).

The APOMM columns about race begin with stories involving one medical student and one patient, but end with more general considerations of race in medicine. Dr. Kimberly Manning, writes in 2014, using the second person narrative voice. An internet search shows that Dr. Manning is a woman of color. She writes a blog entitled "Reflections of a Grady Doctor."[25] In her APOMM column, her words suggest she speaks to a white patient, possibly an amalgam of patients she sees at Grady Hospital, a

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[22] Damon S. Tweedy, A Piece of My Mind, "A Perfect Match," *JAMA* 307, no. 7 (February 15, 2012): 673.

[23] Ibid.

[24] Ibid.

[25] Kimberly D. Manning, "Reflections of a Grady Doctor," accessed February 13, 2017, http://www.gradydoctor.com/.

public hospital in Atlanta, Georgia. Dr. Manning's writing does not include any racially identifying words about the woman, an effective reinforcement for the reader of her stance that race should not influence healthcare. She talks to the patient, formerly of means, now unemployed and in need of treatment at the public hospital; the doctor recounts the various looks in the woman's eyes as she takes in her surroundings, first fearful, but later realizing that she may have more in common with the other patients than she thought.[26] The doctor tries to explain what she hopes the patient sees as she is politely and sensitively cared for, by creatively voicing the hospital's mission,

> But I need you to know that when you don't turn anyone away, sometimes your table gets full. You end up pulling chairs from out of the garage to accommodate the unexpected guests, and you try your best to make sure everybody gets a full serving. You work hard to get someone to help out, and on many days, they do. But even if you find yourself low on resources, you have to keep going since you know that without you, there might not be another place for them to go.[27]

The patient's circumstances improve and she stops going to Grady for treatment.[28] The opportunity to continue the relationship is lost. Dr. Manning wants to accept all comers, seeing her relationships with patients as equal and inclusive. She uses her column to (figuratively) reach out to the former patient, and to other patients making fear-based decisions about seeking care. Dr. Manning tries to make the patient understand the sincerity of the healthcare team, as she tries to understand the woman's reservations about receiving care. She hopes her patient will be a messenger to other patients, suggesting "You could even tell them of how your doctors were the same ones from the university hospital across town and how I helped to give you a piece of your life back. Or

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[26] Kimberly D. Manning, A Piece of My Mind, "If These Walls Could Talk," *JAMA* 312, no. 6 (August 13, 2014): 599-600.

[27] Ibid., 600.

[28] Ibid.

maybe even all of it back. Not because of the person you are but because you're a *person*."[29]

Race is a consistent theme over time in the APOMM columns. Two columns, written in 2008 and 2014, bring *JAMA* readers full circle by addressing the topic of race-based decision-making in healthcare and the quandary for physicians borne of racial profiling by patients.

Decision-making based on race may be overt or subtle, calculated or spontaneous. In 2008, Dr. Reshma Jagsi describes the not infrequent comments she receives from patients who judge her based on her skin color. She recounts a particularly curious scenario when a patient refuses her care before the doctor has spoken, saying "You do have a very thick accent. I could tell the moment I saw you."[30] Dr. Jagsi is diplomatic, allowing that patients are not at their best when newly diagnosed and consulting with her in her role as a radiation oncologist; yet she voices concern about the many missed opportunities that result from such racial bias by patients, writing,

> Comments that in other situations would be nothing less than offensive take on an air of sadness; sadness because some people still cannot see past race as a defining characteristic, sadness because these comments are themselves signs that a patient must be yearning to bond with her physician, sadness because the patient-physician relationship must face obstacles over which I have little control.[31]

Missed opportunities with patients resulting from their racial bias are the crux of the column. Dr. Jagsi takes the high road when she is subject to ignorant opinions. She

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[29] Kimberly D. Manning, A Piece of My Mind, "If These Walls Could Talk," *JAMA* 312, no. 6 (August 13, 2014): 600.

[30] Reshma Jagsi, A Piece of My Mind, "How Deep the Bias," *JAMA* 299, no. 3 (January 23, 2008): 259.

[31] Ibid., 260.

remains respectful, optimistic and supportive of her patients, writing, "Yet in most cases of inappropriate but benignly intended comments, I will continue simply to move on and later explain to my residents that I truly believe that these are signs of a patient's desire to connect, rather than comments worthy of indignation."[32] One wonders how APOMM readers react to Dr. Jagsi's hopeful response to rejection by patients.

Physicians torn between respecting their patients' wishes and possibly being excluded from patient care because of race-based treatment choices write compelling stories in APOMM. Dr. Meghan Lane-Fall is a black anesthesiologist often working in critical care environments. She writes in 2014 about racial bias in healthcare, while trying to interpret both federal law and American Medical Association positions as guides for decision-making, and to understand ramifications for patients.[33] Dr. Lane-Fall observes, "The intimate nature of the patient-physician relationship requires trust and engagement. It is easy to understand how the therapeutic relationship might be undermined if a patient is cared for by an unwanted health professional."[34] Dr. Lane-Fall states she must put her patients' needs above her personal beliefs, writing, "Physicians have an ethical duty to ensure that patients receive needed care."[35] She concludes her column with,

> Does patient-centered care, then, justify tolerating bigotry? In my opinion, yes. I cannot countenance bigotry and other forms of prejudice, but my discomfort with a patient's beliefs does not trump their right to specify the conditions of their care. It is my hope that by affording all patients with the respect that was so often

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[32] Reshma Jagsi, A Piece of My Mind, "How Deep the Bias," *JAMA* 299, no. 3 (January 23, 2008): 260.

[33] Meghan Lane-Fall, A Piece of My Mind, "Accommodating Bigotry," *JAMA* 311, no. 2 (January 8, 2014): 139-40.

[34] Ibid., 140.

[35] Ibid.

> denied to my forebears, the questions I have considered here will eventually become irrelevant to the practice of medicine.[36]

In this column there is no potential for patient-physician relationship, because the physician is not a welcome caregiver. Dr. Lane-Fall's column raises questions for APOMM readers about the medical humanities and the boundaries of patient-physician interactions, perhaps prompting them to explore the meaning of "patient-physician relationship" in different personal, racial, social and humane contexts.

The range of writing on race in the APOMM columns chronologically begins and ends with writings from white medical students documenting the treatment of patients of color. In 2015, medical student Katherine Brooks, who is white, contrasts the lessons she learns in the classroom about racial influences on illness and healthcare, with what she sees in her clinical training.[37] She observes,

> When I arrived in the hospital, I learned to insert my patient's race in the opening of my oral presentation, as though it has as much impact on the medical details to follow as their sex or age. I learned that among two patients in pain waiting in an emergency department examination room, the white one is more likely to get medications, and the black one is more likely to be discharged with a note documenting narcotic-seeking behavior.[38]

The sociologic and anthropologic implications of race on the patient experience and on patient-physician relationships for people of color are elements of the medical humanities, exemplified in select APOMM columns spanning thirty-five years.

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[36] Meghan Lane-Fall, A Piece of My Mind, "Accommodating Bigotry," *JAMA* 311, no. 2 (January 8, 2014): 140.

[37] Katherine C. Brooks, A Piece of My Mind, "A Silent Curriculum," *JAMA* 313, no. 19 (May 19, 2015): 1909-10.

[38] Ibid., 1909.

The authors for the most part are contemplative, in most cases choosing to deliberatively address the racially motivated behaviors they encounter as they provide care. Brooks closes her column with philosophical and ethical sentiment, writing,

> I've witnessed missed opportunities for healing and the loss of patient trust. And I believe that if we refuse to deeply examine and challenge how racism and implicit bias affect our clinical practice, we will continue to contribute to health inequalities in a way that will remain unaddressed in our curriculum and unchallenged by future generations of physicians.[39]

The student's words address the type of interaction she envisions with patients, with equal access to evaluation, care and treatment. When the healthcare delivery playing field is not level, patient-physician relationships may be diminished or fail to form. The lessons in the APOMM columns on race are written for doctors practicing in racially, culturally and socioeconomically diversified urban, suburban and rural settings. Doctors writing on race do a service to physician readers wherever they practice, reinforcing the goal of equality in healthcare and relationships with patients.

The stories about the effect of socioeconomics and race on patient-physician relationships concern social forces as they affect healthcare delivery. Such forces are external to the physician (for purposes of this discussion), posing significant challenges to the physician's perceived satisfaction in the patient-physician relationship. In 2001, Dr. Joshua Hauser wrote on this difficult subject in an APOMM column:

> One of the rewards in medicine is the frequent challenge of connecting to, understanding, and helping people who are unlike ourselves, often in profound ways: whether by illness or injury, by age, by race, by "class." Although the fundamental difference we confront between a patient and a physician is usually the one between sickness and health, we know that other differences can cloud our understanding of each other. That does not mean that we should dwell on

[39] Katherine C. Brooks, A Piece of My Mind, "A Silent Curriculum," *JAMA* 313, no. 19 (May 19, 2015): 1910.

> them, but that we need to recognize them and try to connect with each other despite them or even because of them. When "differences" are shorthand for inequities, we try to fight against them, individually or as groups. When differences are ones of race or culture, religion or age, we try at once to respect and learn from them. All of that is easier written in an essay than done at the bedside.[40]

The challenges from inequality in socioeconomics and the influence of race on medical practice sound daunting in the stories from physician-writers in APOMM. Their decisions to share their thoughts and experiences may stem from, as Dr. Hauser explains above, the ability to tell the story when their ability to change difficult patient circumstance and positively influence health seems frustratingly limited.

The next section of this chapter focuses on medical error, conceptualized as a personal, internal force on physicians caring for patients. Physicians believing they have made clinical errors in judgment tell their stories in APOMM. Other physicians write about the effects of public accusation of error in stories about malpractice.

Errors in Medical Judgment: Personal Perception, Public Accusation, and the Patient-Physician Relationship

A small number of APOMM columns are from authors describing their errors in medical judgment, and six are included in this section. The events surrounding self-disclosed errors in judgment occur at different time points during the careers of the involved physician-writers. Some authors explain feeling overwhelmed by patient circumstances, making mistakes in medical decision-making, or in some cases believing that although their actions were clinically correct, they yielded undesirable outcomes.

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[40] Joshua Hauser, A Piece of My Mind, "The Consultation," *JAMA* 286, no. 22 (December 12, 2001): 2782.

Healthcare professionals may sometimes be overwhelmed by certain clinical situations during their training or careers. They may occasionally feel unsure, be unable to act, or want to leave the room of a patient. A story in APOMM involving such feelings comes from a doctor who is an intern at the time of the event. Dr. Stephen Shultz writes in 1994. He is called to examine an approximately six-week-old infant neurologically decimated by an unstated infection, with no hope of recovery. The intern is unprepared for the unrealistic optimism of the baby's mother and the father's shock at the incomprehensible speed with which infection has felled his son; he flees the room, leaving the parents and their baby.[41] The writer's recollection about his actions involves not only his inability to communicate with the baby's parents, but also his loss of control when he begins to sob in the hallway, as he thinks about his own son.[42] There is no resolution to the story. Dr. Schultz closes with "I cry for a long time. My beeper goes off. I wipe my face, blow my nose. I don't go back in the room, and I don't leave a note. I never see them again."[43]

Dr. Schultz wrote in 1994 about his inability to understand the parents' reaction to their child's condition, and how his own reaction to their situation prevented him from establishing a relationship with them. Perhaps a prescient editorial staff at *JAMA* titled the original invitation to write for APOMM "For the Peace of Your Mind," expecting physician-writers to somehow relieve themselves of particularly overwhelming or difficult clinical memories.

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[41] Stephen Shultz, A Piece of My Mind, "A Father's Eyes," *JAMA* 271, no.15 (April 20, 1994): 1146.

[42] Ibid.

[43] Ibid.

While some writers describe clinical inaction, as in the preceding story, others regret actions they take in caring for patients. Dr. Michael McCarthy, a resident writing in 1993, recalls a seventeen-month-old boy dying in the hospital. The doctor is asked to draw the child's blood. He sticks the boy repeatedly and unsuccessfully, until a concerned nurse suggests he stop to see if the small amounts of blood collected in the failed attempts can be used as a sample.[44] Dr. McCarthy credits the nurse with tactfully sparing him admission of his lack of skill, thus allowing him to avoid notifying his senior resident, whose reaction he fears.[45] The toddler dies after the resident leaves the pediatric service, and Dr. McCarthy remains troubled by his actions, writing that over ten years later he still does not know why he did what he did.[46] The column documents the doctor's ongoing efforts to understand his responsibility in his relationship with the patient.

Sometimes, as in the story above, well-intended care does not yield positive outcomes. Dr. Lawrence Hergott (the author of several APOMM columns) writes about a decision he made as a young cardiologist to put his rather unstable (from a cardiac perspective) patient onto a treadmill to demonstrate cardiac insufficiency, rather than ordering the more standard cardiac catheterization.[47] The patient had expressed a premonition about the stress test to his wife, but did not share his worry with his doctor. The patient dies in the exercise tolerance room shortly after the start of the test, shocking

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[44] Michael P. McCarthy, A Piece of My Mind, "Painful Lessons," *JAMA* 269, no.14 (April 14, 1993): 1872.

[45] Ibid.

[46] Ibid.

[47] Lawrence J. Hergott, A Piece of My Mind, "Playing the *Moonlight Sonata* From Memory; Celebrating the Wonders of Our Difficult Life," *JAMA* 288, no. 20 (November 27, 2002): 2516.

the doctors and nurses.[48] Dr. Hergott opens his APOMM column from 2000 with: "I think about him several times a year even now, more than 20 years later. When I do it is with uncomfortable clarity and a surge of briefly incapacitating sadness and guilt."[49] Here is another example of a physician writing many years after the event, carrying the memory of a clinical judgment he regularly revisits. Speculation on a different outcome if the patient had shared his fear with the doctor serves no purpose. But the story can serve as a starting point for discussion among readers of APOMM about how to practice when faced with good intentions yielding bad outcomes, and the sometimes long-lasting effects of clinical decisions.

Some self-admitted errors in medical judgment involve balancing patient needs with professional practice standards. Dr. Daniel Rayson, then a young hematology/oncology fellow, recounts his inability to talk honestly with a patient about the severity of her cancer and her poor prognosis. Instead he perpetuates the patient's unrealistically optimistic outlook, and when she dies shortly thereafter he wonders if his approach influenced the way the patient spent her last days with her young children.[50] He writes,

> The last words I spoke to her continue to echo. Lisa may not have had enough time to write stories for her children but maybe she could have penned a few words or poems, started a scrapbook, or even tape-recorded thoughts or messages. Maybe her children would have held on to those words as a living memory of the dynamic, carefree woman who was their mother. . . How much of a difference could I have made in those kids' lives if only I had agreed with Lisa's

[48] Lawrence J. Hergott, A Piece of My Mind, "Playing the *Moonlight Sonata* From Memory; Celebrating the Wonders of Our Difficult Life," *JAMA* 288, no. 20 (November 27, 2002): 2516.

[49] Ibid.

[50] Daniel Rayson, A Piece of My Mind, "Lisa's Stories," *JAMA* 282, no. 17 (November 3, 1999): 1605.

> friend that yes, she should write down stories for her children because she was indeed "*that* far gone"?[51]

Dr. Rayson writes years after an experience that continues to color his clinical practice, sharing his story with colleagues as he still wrestles with his treatment decision.

Professional, scientific knowledge mixes with the intangible art of developing relationships with patients to produce effective healthcare. Dr. Joseph Hardison, who authored several APOMM columns, writes about two different patient encounters involving the blending of both sides of medicine, described next.

The first story is about a patient Dr. Hardison saw as an intern. The patient had metastatic prostate cancer and requested pain medication. The young intern cited his professional responsibility to examine the patient before treating. When the patient objected, and asked his personal physician to intervene, the attending physician assured the intern that it was all right to treat the patient first.[52] The intern was in the difficult position between professional responsibility and patient request. The relationship was brand new, and the patient and physician had different goals. The patient wanted pain relief, and the doctor wanted to evaluate the patient before treating him. Dr. Hardison wrote: "It was sometime later before I realized I should not have insisted on a complete history and physical examination before relieving his pain. It has taken me 20 years to admit it."[53] The experience remained nestled in the doctor's conscience until he decided to tell his story.

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[51] Daniel Rayson, A Piece of My Mind, "Lisa's Stories," *JAMA* 282, no. 17 (November 3, 1999): 1605-06.

[52] Joseph E. Hardison, A Piece of My Mind, "An Intern Meets Ty Cobb," *JAMA* 246, no. 17 (October 23/30 1981): 1886.

[53] Ibid.

In another column entitled "Humility," Dr. Hardison wrote about a patient presumed to be an alcoholic based on liver biopsy. The patient's medical team pressed the patient and his family for an admission of alcohol abuse, believing it the only explanation for the biopsy results.[54] When the family repeatedly denied alcohol abuse, the pathologist further researched the initial findings, and learned the patient's results and other clinical findings fit the criteria for a then rarely reported type of hepatitis not associated with alcohol abuse.[55] The team was "embarrassed – ashamed. We didn't know. We apologize for doubting – for not believing."[56] In this story, the team failed to consider alternative explanations for the patient's clinical presentation. Dr. Hardison closes with an observation applicable to physician relationships with patients, and human relationships in general: "Humility (freedom from pride or arrogance) is an admirable human quality. It doesn't come easily and it doesn't come naturally."[57]

Both columns are about Dr. Hardison's (and the medical profession's) attempts to follow the structured routine of assessing, diagnosing and treating patients. The standardization and uniformity of such procedures allows healthcare professionals to think in an orderly, consistent way that often aids in evaluating patients. But such standardization should allow appreciation for the individual circumstance and presentation of each patient that comes from developing relationships through communication and understanding, blending the science and art of medicine.

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[54] Joseph E. Hardison, A Piece of My Mind, "Humility," *JAMA* 247, no. 23 (June 18, 1982): 3193.

[55] Ibid.

[56] Ibid.

[57] Ibid.

Disclosures by physicians about errors in clinical judgment are rare in APOMM. They involve both errors of commission (the resident who repeatedly sticks the dying baby) and errors of omission (withholding pain medication). Two non-physician authors address such disclosures by doctors in *Perspectives in Biology and Medicine*. Delese Wear and Therese Jones maintain "Confessional writing by physicians reflects the human impulse to unburden ourselves of secrets and experiences that cause us guilt or shame, dishonor our relationships, and separate us from those we respect, serve, and love."[58] The physicians who write about their errors explain how their relationships with patients are affected by their action or inaction, and the lingering memory of their decisions.

The APOMM reader must consider how the recollection of an experience has changed in the writer's mind over time. It is easy to read the columns and make a judgment about the writer. It is difficult, if not impossible, to know the context in which the encounter occurred, or how one would react in the same situation. Summarizing the columns also reduces them to a few citations, and cannot truly reflect the magnitude of the personal admissions of the authors. They carry the weight of their decisions years after the fact, still trying to understand what they should, or should not, have done.

The preceding columns address physician self-described errors in patient perception, communication and care. Conversely, accusations of medical error in the form of malpractice allegations are public, creating varying effects on patient-physician relationships. Malpractice accusations are a reality of medical care because human endeavors involve the risk of human error. Innumerable factors contribute to errors of medical judgment, including fatigue, distraction, incompetence and emergency situations.

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[58] Delese Wear and Therese Jones, "Bless Me Reader For I Have Sinned; physicians and confessional writing," *Perspectives in Biology and Medicine* 53, no. 2 (spring 2010): 227.

Columns about malpractice and other legal issues appear from 1985 to 2014 in APOMM, and are few in number. The majority concern malpractice litigation, and the effect on accused doctors. The early columns focus on the single experiences of the authors, while the last of the columns is about the broader subject of tort reform in medicine. They add to a discussion of factors that diminish or prevent relationship-building capacity between patients and doctors.

Narrative voice effectively conveys the distance created between doctors and patients in APOMM malpractice stories. Dr. Stanley Wohl writes in the third person, and his protagonist, the accused, remains unknown to the reader. He opens his 1986 column with, "It all began like so many other cases he had managed in his long career."[59] Dr. Wohl tells the doctor's story, involving deepening depression while awaiting a court date; the doctor is dropped by his insurance carrier for refusing to settle the case, loses his privileges at the hospital where he practices, and ultimately commits suicide while awaiting trial.[60] The story may be fictional, but it may also be the true account of a colleague or acquaintance of Dr. Wohl. The narrative voice captures the doctor's growing isolation for the reader, in a story about the effect of broken relationships.

In a second column the physician-writer describes the mixed feelings of trying to work once accused of malpractice. Dr. Adam Goldstein blends two scenarios into one story, writing in the second person. A doctor, rested from vacation and eager to return to work, describes his first day back in the office. But at the end of each paragraph he inserts one sentence of a notice of malpractice, juxtaposing thoughts about his medical

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[59] Stanley Wohl, A Piece of My Mind, "Death by Malpractice," *JAMA* 255, no. 14 (April 11, 1986): 1927.

[60] Ibid.

practice with thoughts about having been served.[61] The reader is never certain that Dr. Goldstein is the accused. He describes the effects of malpractice litigation on the practitioner: "You feel suspicious towards patients whose diseases do not conform; anger at a system that waits for the inevitable and then says 'I told you so,' failure at yourself for not saving all patients from all diseases; frustration with a society that may forsake trust for technology, color for black and white, uncertainty for absolutes."[62] Dr. Goldstein conveys a certain distancing of the doctor from patients, the medical profession and society in general with his words. His comments about the demand for absolutes in medicine echo earlier words of Dr. Wohl, who reminds readers of the unpredictability of medicine, writing, "patients are not machines and that they sometimes react to appropriate, competent therapy in unexpected ways."[63] Dr. Goldstein's words explain the effect of malpractice accusation on physician approaches to patients, and remind readers that in medicine, sometimes good intent yields unfortunate and unintended outcomes.

There are alternative APOMM stories from the two just cited, involving unexpectedly positive aftermaths of malpractice accusations. One story concerns a physician consulting in the care of a diabetic patient who loses his leg and later files a malpractice suit in which the doctor is named. During litigation, the patient presents to the dialysis unit where the author, Dr. Michael Kovalchik practices.[64] After wrestling

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[61] Adam O. Goldstein, A Piece of My Mind, "Coming Home," *JAMA* 265, no. 9 (March 6, 1991): 1099.

[62] Ibid.

[63] Stanley Wohl, A Piece of My Mind, "Death by Malpractice," *JAMA* 255, no. 14 (April 11, 1986): 1927.

[64] Michael T. Kovalchik, A Piece of My Mind, "Theo's Story," *JAMA* 266, no. 23 (December 18, 1991): 3340.

with his personal thoughts, his professional responsibility prevails and he begins to treat the patient; one and one half years later, the doctor is told the patient has dropped the lawsuit.[65] The doctor's assessment of the situation is as follows: "By listening to him and validating his concerns, I had fostered a relationship that bridged our differences."[66] He achieves an unexpectedly positive outcome after the negative experience of the malpractice accusation. Dr. Kovalchick reinforces the value of having patience and presence with the patient, to broaden an understanding of the patient's situation.

Another column, from 1997, also demonstrates sensitivity on the part of a doctor accused in a malpractice case. The lawsuit is ultimately dismissed, but two years later the doctor finds herself caring for the infant daughter of the plaintiff's attorney. Dr. Linda Sacks calmly and deliberatively explains to the attorney father that despite their history, she is confident she can care for the child, but would understand if he wanted his daughter treated elsewhere.[67] The father explains that the case was his only experience in malpractice litigation as a very inexperienced lawyer, and that he wants his child treated by Dr. Sacks.[68] The infant has a complicated hospital course and is ultimately diagnosed with chronic neurological sequelae of her premature birth. Father and physician develop a good relationship, and Dr. Sack's reflects on the experience about a year later: "My experience with Annie and her parents taught me about honesty, integrity, compassion,

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[65] Michael T. Kovalchik, A Piece of My Mind, "Theo's Story," *JAMA* 266, no. 23 (December 18, 1991): 3340.

[66] Ibid.

[67] Linda M. Sacks, A Piece of My Mind, "Res Ipsa Loquitur," *JAMA* 278, no. 6 (August 13, 1997): 471.

[68] Ibid., 472.

forgiveness, communication, and unconditional love."[69] Dr. Sachs explains her position and concerns, overcomes her hesitation, and treats the patient and her family objectively and professionally to positive ends. Understanding and insight are central to the physician's definition of relationship with her patient and the parents.

Relationship building between patients and physicians under challenging circumstances is at the heart of the two columns referenced above, involving interpersonal reconciliation between the parties in matters of caregiving and receiving. In both cases, the authors describe listening and understanding as equally important to words spoken by the patients and doctors involved.

The relationship between plaintiff and jury is the subject of another column. Dr. Thomas Schwenk, the plaintiff, writes in 2014 about his acute loss of control and dependence on a jury: "Eight people, whose only real criterion for involvement is that they live in the same county where I practiced medicine, will be asked to understand a complex set of often conflicting medical facts and reconcile competing portrayals of my medical decision making."[70]

Elements of the story referenced above can be applied to an understanding of the relationship between patients and physicians. Dr. Schwenk shares his thoughts about speaking to members of the jury. He observes,

> I am persuading the jurors that I am a fundamentally good and prudent physician. I am trying to explain the very essence of who I am as a physician, and trying to do so in a way that is simple but not condescending, sophisticated but not obtuse, confident but not arrogant, concerned but not disingenuous, all in front of the

[69] Linda M. Sacks, A Piece of My Mind, "Res Ipsa Loquitur," *JAMA* 278, no. 6 (August 13, 1997): 472.

[70] Thomas L. Schwenk, A Piece of My Mind, "The Moment of Truth," *JAMA* 311, no. 6 (February 12, 2014): 573.

> plaintiff, family members, maybe the press, and random members of the public who may wander in.[71]

How similar these goals sound to communicating with patients. The doctor is aware the jurors (like patients) may not be fluent in medical terminology, clinical decision-making or medical practice standards, but hopes to effectively communicate his professional standards and ethics to them.

The most broad of the *JAMA* columns about legal matters is an accounting of the effect of malpractice litigation on the medical profession rather than about a specifically named defendant. In a 2011 column Dr. Peter Kowey reviews literature on malpractice litigation. He explains the net effect as the practice of defensive medicine, which chokes healthcare delivery systems with unnecessary testing by fearful doctors ordering extensive tests and procedures, sometimes after being accused of negligence in the care of their patients.[72] Dr. Kowey contends that doctors must become involved, writing, "It is time for the physician silent majority to actively support tort reform."[73] His defining and safeguarding of the patient-physician relationship addresses the medical tenets not only of providing necessary care, but of protecting patients from unnecessary care as well.

This chapter concerns forces unlikely to change in physician care of patients. They include the effect of socioeconomic inequality and race on access to care and treatment outcomes, and the personal and professional ramifications of medical error. Another influence on patient-physician relationships is the effect of business models applied to healthcare. Business models address client or customer base, services, costs,

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[71] Thomas L. Schwenk, A Piece of My Mind, "The Moment of Truth," *JAMA* 311, no. 6 (February 12, 2014): 573.

[72] Peter R. Kowey, A Piece of My Mind, "The Silent Majority," *JAMA* 306, no. 1 (July 6, 2011): 18.

[73] Ibid., 19.

revenue and profit (in very broad terms). While changing business practices in healthcare are addressed in some APOMM columns over the course of publication, the authors consistently focus on how those practices affect the patient-physician relationship.

The Business Model and Patient-Physician Relationships

Some of the APOMM columns about factors that diminish patient-physician relationships involve thoughts not typically shared by physicians with their patients, and those about the effect of business model influences on medicine are examples of such columns. As early as 1982, physician-writers in APOMM consistently expressed dissatisfaction and frustration with business approaches to clinical care. Dr. Alex Tulsky described his first realization that patients had become "clients" while reading nursing notes to learn about the status of his hospitalized patients:

> It disconcerted me to find that the patients I have taken care of for many years have magically become "clients". . . I know we are now purveyors of health care in what has become an industry and our patients of yesterday are consumers of health care today. Perhaps it belabors the point, but I find "client" an inexorable extension of the health care industry mystique, and it fills me with an ineffable sadness. Perhaps I am a latter-day Don Quixote tilting at contemporary windmills, but I ask very little - only to take care of patients.[74]

Dr. Tulsky's words may sound provincial and old-fashioned to readers learning and practicing twenty-first century medicine, but they embody the sentiments of other APOMM writers regarding the challenge of assimilating business influences into healthcare. He seems to want a simpler approach to patient care and relationship, shielded from marketplace contaminants.

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[74] Alex S. Tulsky, A Piece of My Mind, "Patients and Clients," *JAMA* 247, no. 9 (March 5, 1982): 1279.

Fourteen years later, in 1996, Dr. Odysseus Argy writes about not only demanding business realities in medicine, but the many additional challenges in providing care to patients. He identifies seven standards of care that apply to patient-physician encounters. They are: the idealized standard of care, the academic standard of care, the practical standard of care, the medico-legal standard of care, the economic standard of care, the managed care standard, and the personal standard.[75] The standards address physicians' responsibilities towards patients, and each standard requires a different approach to the patient-physician relationship. For example, the doctor focusing on the medico-legal standard of care may order more diagnostic tests and procedures than the doctor considering the practical and economic standards for a patient of limited means.[76] The personal standard especially relates to the subject of this chapter. Dr. Argy writes,

> It is an incorporation of all of the above [the six other standards] in some form but is unique to each physician. It is influenced by experiences from medical school, training, and practice, as well as personal experiences with other physicians, patients, and the legal system. More importantly, the personal standard also incorporates a part of the individual physician's moral, ethical, and humanistic code of conduct, and what he or she feels is the "right thing to do" for any particular patient. It is the personal standard of care that allows a physician to establish the uniquely trusting and interactive relationship between himself and his patient. The physician is thus better able to educate the patient about medical issues, thoughtfully listen to and address the patient's needs and desires, and incorporate the patient as an active participant in an individualized care plan. In this setting, the patient is a human being and not simply a "covered life, a "customer," or a "case."[77]

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[75] Odysseus Argy, A Piece of My Mind, "Standards of Care," *JAMA* 275, no. 17 (May 1, 1996): 1296.

[76] Ibid.

[77] Ibid.

Dr. Argy's explanation of the personal standard is a description of many elements of the humanities as they pertain to medical practice. The application of the doctor's individual beliefs and philosophy of care can prove challenging within the confines created by the practical demands of healthcare delivery, as detailed in the other standards.

Another APOMM writer is angry in her column about healthcare. Dr. Naomi Bluestone expresses her profound concern about the practice of medicine, writing in 1993:

> My opinion is that our health care mess began not with the advent of space-age technology but when intimacy in the physician-patient relationship became a dispensable item.
>
> The desire for a relatively timeless and private communion that enables the free-flow outpouring of personal suffering is so universal across time and continents, one would think it would not be discarded lightly.[78]

She resents the encroachment of business influences on her profession, writing in a way that shows her understanding of the close and sensitive bonds possible between patients and their doctors, and her animosity towards business influences threatening such relationships:

> Surely those who send intimacy to the block have never known the terror of urinating into a toilet bowl that is reddening with arterial blood or the horror of running soapy fingers over a comfortable old breast that has grown a silent, menacing lump. Confidentiality is also being tossed away with the dirty bathwater of the new medicine, a needless luxury to those who do not know the shame disease can cause, or the desire it can arouse to protect one's family from pain. The aggressive but self-deluded young entrepreneurs, who see a growth industry ripe for revolution and therefore up for grabs, could not possibly pursue their rapacious takeover of a wounded profession if they had any sense of how needy and regressed a sick human being generally is and how desperately patients need to share their inner turmoil in a timely way with caring physicians and nurses.
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> No competitive market of "managers," no universal payer, no innovative distribution technology can succeed if it overrides this basic truth: **Human beings need to relate**.[79]

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[78] Naomi Bluestone, A Piece of My Mind, "The Bottom Line," *JAMA* 269, no. 19 (May 19, 1993): 2580.

[79] Ibid.

Drs. Tulsky (1982) and Bluestone (1993) advocated in different ways for preserving the uniqueness of patient-physician relationships in the face of business influences on medicine, years before the business model further transformed healthcare to its current state. The opinions of the three authors referenced above escalate concern about business influences in medicine from measured explanation (Dr. Argy), to sadness (Dr. Tulsky) to anger (Dr. Bluestone).

The challenges and negative effects of the business model in medicine remain the subject of APOMM columns over the course of the publication period. Dr. Steven Ringel writes in 2003, making observations about medical education and practice:

> At some level we know that the goal of medical education is to foster caring relationships between patients and physicians, but there is insufficient time or reward to act as a role model for such needed behavior. . . We have created a health care system that fosters assembly-line efficiency in performing tests and procedures but has little time and resources left for personal interaction and communication. . . Every one of us would benefit from a health care system that promotes a caring, responsive atmosphere and provides adequate time and compensation for regular patient-physician communication. Yet the demands of today's health care system are moving us further from that goal as payers approve expensive tests and medications but are less willing to pay for the time it takes to talk to people in distress.[80]

The APOMM authors regularly defend the importance of the patient-physician relationship in their efforts to provide care.

A strength of the APOMM columns for readers is the often-straightforward message of the physician-writers. Dr. Robert Edelstein details the challenges he faces with his colleagues in private practice in 2009. He explains,

> In practice, I now spend an almost equal amount of time thinking about running "the business" as I do in directly caring for patients. . . We have the unusual business model in which third-party payers tell us what our services will bring,

[80] Steven P. Ringel, A Piece of My Mind, "Patients Like Linda," *JAMA* 290, no. 2 (July 9, 2003): 166.

> and we, for the most part, have to go along with it. Like any practice, we are faced with the double challenge of falling reimbursements and rising costs. We struggle to provide the best, ethical care we can in a climate where some in society will hold us accountable for anything less than a perfect therapeutic outcome, forgetting that the natural history of disease still can prevail over our centuries of medical knowledge.[81]

Drs. Ringel and Edelstein raise practical and rather philosophical concerns about the effect of the business model in medicine, with a focus on implications for the relationship between the patient and the doctor. Their APOMM columns exemplify consistent efforts of physicians to improve their understanding of patients, and preserve the patient-physician relationship, despite influences that can diminish the practice of such art in medicine.

Some columns focus on changes necessary in healthcare to fortify the patient-physician relationship. Dr. James Webster details suggestions for reducing healthcare costs. He asks colleagues in his 2011 column to consider changing their practice habits by questioning the value of diagnostic tests, prescriptions and procedures before automatically ordering them, as a way to make thoughtful, appropriate choices for each patient.[82] He observes, "These proposals require a major restructuring of the culture of medicine, which will be a tough sell, difficult, and occasionally painful. However, I believe that they are in the best traditions of the profession: improving care outcomes and enhancing patient-physician interactions and relationships."[83] The author's sentiments concern the foundational relationship in medicine between patient and physician.

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[81] Robert A. Edelstein, A Piece of My Mind, " 'Minutes From Fishing and the Opera'," *JAMA* 301, no. 24 (June 24, 2009): 2534.

[82] James R. Webster, A Piece of My Mind, "Fix It!," *JAMA* 306, no. 23 (December 21, 2011): 2544.

[83] Ibid., 2545.

Similarly, Dr. Michael Monroe bemoans the corporate flavor of modern medicine in general, writing in 2011 after fourteen years in practice,

> Medicine today is science, and business, and law (perhaps not in that order) but not so much art as it seemed to be even when I started. . . The bureaucratization of medicine with increasingly complex rules, codes, algorithms, prompts, bylaws, schedules, and administrative structures is leaving its mark, but medicine at its fundamental is still about suffering, healing, and comforting; it is about individuals; it is about relationships and trust; it is about stories.[84]

Dr. Monroe ponders the practice of modern medicine and medical education, upholding the importance of the patient-physician relationship, reminding his colleagues of what he thinks matters most in clinical care.

* * *

The columns cited in this chapter showcase factors the APOMM authors think diminish patient-physician relationships: socioeconomics, race, errors in professional judgment and business practices. The doctors explain their understanding of the effect of these influences on their attempts to build rapport with patients. Columns about the effect of socioeconomics and race on access to care involve ethical and philosophical considerations of healthcare as a right or a privilege. The columns about errors in clinical judgment involve personal perception of error, and the psychological effect of self-accusation versus public accusation as in charges of malpractice. Columns about business practices in medicine remind readers about the complicated legislation, distribution and administration of private and publically funded healthcare. And, in addition to all of the challenges and influences described, the physician-writers remind colleagues that the practice of medicine is also an imperfect science and art.

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[84] Michael H. Monroe, A Piece of My Mind, "Drawer on the Right," *JAMA* 305, no. 12 (March 23/30, 2011): 1176-1177.

The columns expand reader comprehension of the humanities in medicine, by including the influences of personal philosophy, ethics, sociology, anthropology and psychology on caregiving. Those columns referenced in this chapter involve generally consistent human reaction (physician responses to limited socioeconomic resources, race-based decision-making, professional judgment errors and business practices in medicine) despite the changing landscape of healthcare delivery over the course of APOMM publication. The writers focus on protecting and preserving the patient-physician relationship.

The next chapter concerns the effect of technologic influences in the form of data gathering and management on medical care, (especially the electronic medical record), and consequently on patient-physician interaction, communication and understanding.

CHAPTER FOUR

GATHERING AND MANAGING PATIENT DATA: EFFECTS ON THE PATIENT-PHYSICIAN RELATIONSHIP

This chapter is about how methods of electronically gathering and managing patient data for use in clinical care influence communication and relationships between patients and physicians. These methods include the extensive use of numbers and quantification in medicine, the creation of the medical record (described in Chapter One) and electronic communication with patients. The effect of these techniques on patient privacy also can influence the patient-physician relationship.

The use of electronic information-gathering technology in clinical care is considered a social and cultural change for the purposes of this discussion about the medical humanities and patient-physician relationships. Use of such technology has increased over the course of the APOMM publication period; data gathering and management are now ingrained in everyday life, including healthcare, and the APOMM authors cover varied terrain with their opinions. Some speak to excessive reliance on data at the expense of qualitative information about the patient, writing negatively about the resultant objectification of the patient's story. Other authors are more positive, explaining that electronic communication and information sharing enhances their ability to work with patients.

Approximately twenty-five columns published between 1982 and 2015 were considered for inclusion in this chapter; ultimately fifteen were chosen as examples of physician opinion about the effect of data gathering and management on the patient-physician relationship. The columns span the course of APOMM publication, showing

consistency in the theme. However, there are more columns from 2002 to present (fourteen of the fifteen referenced), as compared to the first twenty-two years of APOMM. This distribution reflects the increasing presence of electronic and computerized data collection methods in medicine over time.

User attitudes towards information-gathering technology influence sentiment about the perceived value of systems designed to improve delivery of care. Many of the APOMM writers focus exclusively on the introduction of the electronic medical record (EMR) into clinical settings, often considering it an especially negative influence, vis-à-vis patient relationships. Others write about data gathering and management in medicine differently, seeing benefits of using new technologies to expand a doctor's patient communication repertoire.

This chapter explores both positive and negative physician thoughts about the effect of data gathering and management on an understanding of, and engagement in, professional relationships with patients. The chapter begins with a discussion about the use of numbers in medicine, a precursor to the eventual use of electronic methods to gather and manage data in healthcare settings.

The Use of Numbers in Medicine

A critical element of healthcare is the reliance on numbers to assess patients. One early APOMM writer focuses on this subject in her column. Dr. Nancy Greengold writes in 1994 about the prevalence of numbers in modern medicine, describing those used to assess newborns (the Apgar Score), the stages of disease (I-IV) used in cardiac and cancer diagnoses, as well as the numbers used to classify states of consciousness

(Glasgow Coma Scale), and various numerical scales for assessing degrees of depression.[1]

The numbers represent the science of medicine, while the doctor's interpretation of the patient's story represents the art. Dr. Greengold supports the use of both skills, writing, "We need numerical validation. . . Indeed I had been taught in medical school to describe the world by the numbers."[2] But she also addresses the negative effect of relying too heavily on numbers, observing, "We forego the discriminating richness of our language to embrace the homogeneity of number. . . In the attempt to tabulate, compute and graph the subjective, we use rating scales to adorn our otherwise fishy assessments with their scientific aroma."[3] Dr. Greengold describes a reliance on numbers to legitimize clinical scenarios. When symptoms do not add up to a definitive diagnosis, when the patient's story is not logical or clear, when something just does not make sense, she knows clinicians use numerical values to fortify the story. Dr. Greengold suggests that in those moments, clinicians use numbers to make the story somehow more medically valid, embracing the objective data as more solid than a qualitative interpretation of the patient. Thus the practice of modern medicine increasingly involves quantifying, rather than understanding the patient.

Dr. Greengold's observations were a harbinger of what would come to medicine in the years following her residency. Numbers would increasingly replace the written word as data acquisition expanded in healthcare. Additionally, since the 1980s and 1990s,

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[1] Nancy L. Greengold, A Piece of My Mind, "By the Numbers," *JAMA* 271, no. 12 (March 23/30, 1994): 890.

[2] Ibid.

[3] Ibid.

desktop computers and handheld devices have gradually become the command centers of medical care from which clinicians monitor patient diagnosis, status, treatment and outcome.

Another example of the influence of numbers, and electronic data management in healthcare concerns the physical examination. Upon examination, patients' bodies are revealing of the lives they contain. Ideally, the patient grants permission to the doctor to touch, to listen, to interpret. Such physical encounters provide information to the doctor, and can contribute to establishing or strengthening the patient-physician relationship. In 2013 two APOMM authors, Drs. Andrew Olson and Lawrence Tierney, write about the preponderance of numbers and acronyms in medicine used to describe the physical examination of patients; they argue that using language instead shows proper respect for the act of seeing and touching the patient, an expression of the art of medicine.[4] The physical examination is perhaps the ultimate form of communion and trust between the sick and their healers, and the authors advocate preservation of this intimate experience with words, as evidence of the doctor's discernment of the patient's body, and the patient.

The two practitioner authors cited above look to the future, expressing concern for those aspiring to careers in medicine. Drs. Olson and Tierney regret that medical students are encouraged to adopt the practice of reciting numbers (laboratory values and test results) as they make daily rounds on their patients, allowing the numbers to replace descriptive language about the patient and the patient's illness.[5] They sound earnest in

[4] Andrew P. J. Olson and Lawrence M. Tierney Jr., A Piece of My Mind, "Remarkably Wise," *JAMA* 309, no. 7 (February 20, 2013): 669-70.

[5] Ibid., 669.

their desire to resist the dehumanizing effect of using objective values to represent the human being, intoning a literary respect for the patient's circumstance. They write,

> Our calling as physicians is to tell our patients' stories, stories that should float with descriptive language befitting their importance. . . We have the great privilege of telling our patients' stories – stories they relay to us with their words. . . [T]hey should be told in a way that relays our reverence for the joy in our art . . . and for the intended use of the English language.[6]

The authors sound determined to preserve the sanctity of touching the patient, and using language rather than numbers to share what they see, hear and feel, encouraging their colleagues (present and future) to do the same.

As the patient is examined, evaluated and assessed, records of each observation and interaction are maintained. The use of numbers and quantification not only are a feature of the physical examination, but of documenting patient treatment and response in the medical record as well. This is the subject of the next section of this chapter.

Creating the Medical Record: Writing the Story or Collecting the Data?

In the early years of APOMM, medical records were still being created with handwritten notes from many members of the healthcare team. The records involved the use of numbers as described in the previous section, but also the use of narrative explanations of illness. As computers were introduced into workplaces including healthcare settings, the transformation of the handwritten medical record to an electronic file began. Today, electronic medical record systems are used in many inpatient and out-

[6] Andrew P. J. Olson and Lawrence M. Tierney Jr., A Piece of My Mind, "Remarkably Wise," *JAMA* 309, no. 7 (February 20, 2013): 669-70.

patient settings, and such systems are the focus of several APOMM writers, many with negative sentiment.

The electronic medical record includes many screens with multiple check boxes and limited alphanumeric character fields for observations formerly made via handwritten notes. While there are also limited open text fields, the APOMM authors focus on the preponderance of numerical fields as particularly symbolic of the EMR. Almost all the physician-writers dislike the replacement of descriptions (words) with descriptors (numbers) to tell patients' individual illness stories. Dr. Bradley Fanestil writes with irritation about the perceived superiority of quantitative data in patient assessment, stating, "As if health care happens on the monitor or the silicon chip in my laptop. As if I really improve a patient's health by making sure the correct box is checked on a certain template in my EMR. . . Is there any room in a software 'metric' and a pay-for-performance program for the *art* of medicine?"[7]

Part of the art of medicine lies in conversations doctors have with patients to exchange stories and establish relationships. They share information so the doctor can develop a plan of care, preserved in the medical record or office chart. The physician-writers are frustrated by the EMR, feeling it interferes not only with obtaining the full story the patient tells, but poses a risk of getting and perpetuating incorrect data as descriptions are codified into numbers and "yes/no" boxes. Several of the APOMM authors also describe the EMR as a distraction, forcing them literally to turn away from the patient in order to enter data into the system. In 2015 Dr. Jayshil Patel wrote about his inaccurate assessment of a patient because of his reliance on information in the electronic

[7] Bradley D. Fanestil, A Piece of My Mind, "The Tyranny of the Measuring Cup," JAMA 301, no. 15 (April 15, 2009): 1515-16.

medical record. He explained, "I failed to observe both the respiratory failure and the suffering. . . I missed an opportunity for humane intervention. . . Because all I was concerned about were the numbers."[8] The APOMM physician-writers object to forced professional reliance on the EMR, describing it as impeding interpersonal and storytelling moments with patients.

Some APOMM authors address the effect of increased dependence on numerical and objective descriptors versus qualitative patient assessments on medical education. Three writers using patient narratives to work with medical students on enhancing listening skills explain,

> The narratives provide an additional element of emotion for students. With limited time to build rapport, many students may not have the opportunity to hear first-hand a patient's entire illness experience constructed within a narrative format; instead, they receive information second-hand from electronic medical records, rounds, and reports from the health care team.[9]

The authors argue the importance of two essential and inseparable opportunities for medical students: time to listen to patients, and time to glean details and intricacies of the patient's story.

Some of the authors try to appreciate and accept the mechanization of data gathering in patient care. Dr. Ellen Feldman writes in 2010,

> A computer list really cannot capture the difficult balance involved in connecting with fragile patients and making a difference in their lives. But by holding on to techniques that work while allowing in new ones, we clinicians can continue to do good work while still meeting 21st- century expectations for accountability and clarity.[10]

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[8] Jayshil J. Patel, A Piece of My Mind, "Writing the Wrong," *JAMA* 314, no. 7 (August 18, 2015): 671.

[9] Kathryn A. Cantrell, Sylvia Sutton and Aditya H. Gaur, A Piece of My Mind, "Pause, Listen, Share," *JAMA* 312, no. 4 (July 23/30, 2014): 346.

[10] Ellen Feldman, A Piece of My Mind, "The Day the Computer Tried to Eat My Alligator," *JAMA* 304, no. 24 (December 22/29, 2010): 2679.

Dr. Feldman sounds as though she is trying to convince herself and her readers of the merits of the EMR.

The negative columns about computers and the EMR serve as jumping off points for authors to express other concerns. One physician also writes about the need to focus on patients, essential to the goal of providing a feeling of care, concern and physical and emotional interaction. Dr. Steven Angelo shares a story about his thoughts when the hospital computer network goes down one day. He appreciates the respite, and the pleasure of reverting to old-fashioned bedside practice by necessity, as he watches the reactions of patients, nurses and doctors when they realize the screens normally containing data are blank.[11] He observes that all of the staff have left the nurses' station and are in patient rooms, performing assessments by looking at, talking with and touching patients, instead of the keyboards and screens at the computer stations. In 2002 he writes,

> A half-hour later, the computer system is running again, and like moths to a light bulb, the unit staff eagerly huddles around the computer screens to check their patients' numbers. There is a palpable sense of relief, but for me there is melancholy, because for a brief moment, I saw what true patient care could be like, without technology's oftentimes distracting presence.[12]

The loss of connection to the data that are supposed to best represent the patients is the very thing that reconnects the staff to the patients in Dr. Angelo's story. Data capture and storage can bring increased speed and accuracy of diagnosis, making users dependent on the systems; but some authors feel the systems distance doctors from the patients whose data they collect. Although Dr. Angelo writes about the negative effect of

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[11] Steven J. Angelo, A Piece of My Mind, "A Wake-up Call," *JAMA* 287, no. 10 (March 13, 2002): 1227.

[12] Ibid.

computers on patient-physician relationships, he uses the failure of the computers as an opportunity to be present with his patients, considering such presence essential to his work with them. Dr. Angelo reminds his colleagues that there is so much to be learned by being with the patient, at the bedside, instead of sequestered at the computer station.

The concerns of the APOMM writers differ based on when in their careers they face the introduction of the EMR in their practices. Dr. John Frey, a doctor approaching retirement, writes very personally in 2007 about his cherished handwritten office charts, and what he feels he loses when using the EMR. He believes that his handwritten notes preserve his observations and memories of patients, helping him practice and making him a good colleague to his partners, who may be called upon to care for his patients.[13] He says, "The memories have always been tied to the words. I suppose that my concern about electronic health records and their templates is about losing the words that have connected me with generations of patients."[14] One wonders whether younger physicians well versed in electronic data gathering and management systems would describe feeling similarly connected to patients via the electronic medical record.

Dr. Frey's column is a lamentation about his perceived loss of professional identity due to the EMR, as he approaches the end of his career. His themes concern the two losses he faces: his written testimony about patients (replaced by the EMR), and his physical presence with patients (through retirement). Although he is told that he can customize certain fields of the electronic record, he believes such customization will

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[13] John J. Frey III, A Piece of My Mind, "At a Loss for Words," *JAMA* 297, no. 16 (April 25, 2007): 1751.

[14] Ibid.

inadequately describe the nuances of his patients and their stories.[15] Dr. Frey makes his efforts to preserve the language he equates with his identity as a physician, and tangible evidence of his relationships with patients, sound futile in the increasingly electronic practice of medicine.

While Dr. Frey sounds defeated in the face of electronic healthcare, some younger authors write tentatively of their developing relationships with the computers they know they must use in daily practice. The doctors write about trying to acclimate to new technologies and related changes in work. Dr. Ellen Feldman (cited earlier), eyes the new computer in residence on her desk, intruding on several carved wooden animal figures she uses to engage her pediatric patients in conversation during visits; the collection of objects now includes a computer and printer.[16] Dr. Feldman writes about the difficulty of learning to live with this palpable invasion of her workspace. She is a child and adolescent psychiatrist anticipating the effect electronic record keeping may have on her practice. As she tries to accommodate the change and embrace the projected benefits, she feels,

> [S]till I struggle with the computer coming between my patients and their stories and our connection. . . For all the waste, duplication, and lost time there was with the old system, there is also a long and valued history of taking care and in caring about these people: our patients, not our clients, and not faceless numbers on a chart.[17]

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[15] John J. Frey III, A Piece of My Mind, "At a Loss for Words," *JAMA* 297, no. 16 (April 25, 2007): 1752.

[16] Ellen Feldman, A Piece of My Mind, "The Day the Computer Tried to Eat My Alligator," *JAMA* 304, no. 24 (December 22/29, 2010): 2679.

[17] Ibid.

Dr. Feldman suggests that words show more reverence for patients and patient-physician interactions than numbers. She sees the computer as an intrusion, yet it resides amongst the animal carvings that help her work with patients.

On the other hand, Dr. Robert Hirschtick is pessimistic, making strong cases against the EMR in two columns published in 2006 and 2012. He takes an unsentimental approach, advocating for patients not by writing about close patient-physician relationships, but with a clarion call about how doctors generate, and have come to rely on, a fallacy in the form of the EMR.[18] The doctor is an articulate detractor of the electronic medical record and offers specific examples of how bad data are propagated, thus rendering the EMR technically incorrect and almost clinically useless in his earlier column entitled "Copy-and-Paste."[19]

Dr. Hirschtick expresses his concern about the quality of the EMR, which he feels is inferior to the handwritten record. His column cleverly includes one paragraph repeated three times, and a second paragraph repeated twice, as an example of how unnecessary information is replicated by the act of copying and pasting. He writes,

> While EMR is highly efficient in producing notes, virtually all of its notes are longer, recombinant versions of previous notes. Even notes of different authors are morphed by EMR into clones of one another. As physicians have become more adept with the time-saving features of EMR, their notes have been rendered incapable of conveying usable information by their bloated and obfuscated nature.[20]

The copy-paste feature of computers allows users to copy information rather than rewriting it, placing the copied text elsewhere in the record, including any errors it may

[18] Robert E. Hirschtick, A Piece of My Mind, "Copy-and-Paste," *JAMA* 295, no. 20 (May 24/31, 2006): 2335-36.

[19] Ibid.

[20] Ibid., 2335.

contain. In the case of the EMR, this allows users to carry forward elements like patient histories that have been obtained by other practitioners, and are presumed to be correct. Dr. Hirschtick's patient advocacy in the face of such EMR practices is clear and paramount.

By 2012, Dr. Hirschtick is more resigned in his opinion of the EMR, sounding weary and defeated. He opens with "The electronic medical record (EMR) has transformed the nature and purpose of the hospital progress notes."[21] The transformation is bad, according to Dr. Hirshtick, who explains that the electronic notes contain not only the repeated errors of the copy-paste practice, but also notes by many healthcare professionals throughout the day of a hospitalized patient. He writes, "But EMR notes are not real-time notes in a linear sense. Some portions of these notes are written before, some during, and some after the events they describe. . . Time spills over from one day's note to the next. At the end of the day, there is no end of the day."[22] The doctor's sentiment concerns the potentially negative effect of the EMR on the goal of orderly continuity of care for patients. Dr. Hirschtick writes, "The long and winding road of EMR progress note construction results in notes that are read by few and appreciated by fewer. . . They are created by individuals with great talent, the results are awful, and nobody seems to mind."[23]

Data gathering and management in medicine includes not only the EMR, but electronic means of communication with patients as well. In 2012, Dr. David Wu shares a

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[21] Robert E. Hirschtick, A Piece of My Mind, "John Lennon's Elbow," *JAMA* 308, no. 5 (August 1, 2012): 463.

[22] Ibid., 464.

[23] Ibid.

feeling of loss in his relationships with patients due to the information technology facets of his practice, while also acknowledging the merits of data collection and management. He writes:

> Please don't get me wrong. I am not a technophobe or some sort of anachronistic curmudgeon, longing for the days of carbon copies and overstuffed paper charts. I appreciate the grand benefits of the EMR, the way it provides efficient access to information, computerized checks for drug interactions, ease of communication among health professionals. . .
>
> But I fear that, under this system, I'm not as good a doctor as I once was. What I mean is that I've come to prize what the system prizes: efficiency over human contact, computerized data over stories, virtual reality over authentic life. I may be pretty efficient at processing and acting on data, but I'm not as compassionate, not as good a listener, not as human. More and more, I have felt myself becoming a kind of virtual doctor.[24]

Despite the advantages of electronic data in his practice, Dr. Wu shares his concerns about the disadvantages with his professional community in APOMM. How difficult it must be to create and sustain relationships with patients given such mixed sentiment.

When people are sick they make appointments to "see" the doctor, not the computer, laptop, or handheld device. In 2012, Dr. Caroline Wellbery writes pessimistically about the influence of electronic data gathering and management on medical training and how doctors "see" patients. Dr. Wellbery is a family practice physician who fears the effects of data collection and use on both medical education and the act of caring for patients. She observes, "Our focus on our machines takes away from this sort of raw presence that was once considered almost sacrosanct. The threesome with our devices has altered the terms of our engagement. . . We are learning to come to terms

[24] David Wu, A Piece of My Mind, "Virtual Grief," *JAMA* 308, no. 20 (November 28, 2012): 2095-96.

with the altered nature of our communication."[25] Dr. Wellbery describes replacement of the former patient-physician dyad with the patient-physician-electronic device triad, seeing the data gathering now present in medical care as a threat to the intimate act of caring for the patient. She wonders, "Will our reliance on the information we receive interfere with our critical faculties? These devices, instant as they are, deprive us of the very essence of presence, which is steeped in context, shaped by the past, and informing the future. We may be surrendering our capacity to be in the moment. . ."[26] Dr. Wellbery and other APOMM authors suggest the devices distract healthcare professionals from being enlightened by their patients, diminishing the development of therapeutic relationships.

Data gathering and managing tools in medicine represent what many APOMM authors feel are negative changes in medical practice. Their words, particularly about the EMR, mingle with concerns about what is lost in the patient-physician relationship: time to truly converse with patients is lost to asking a series of questions and translating the answers into cryptic bits and pieces to populate electronic fields; time at the bedside is lost to computerized management of care; time to hear the patient's story is lost to the accelerated pace of care fueled by electronic systems designed to collect more data. The stories of patients are truncated into the required fields of electronic systems, and many of the APOMM physician-writers sound irritated and disappointed in the wake of technologic advances in healthcare as symbolized by the EMR. The act of turning

[25] Caroline Wellbery, A Piece of My Mind, "Our Ubiquitous Technology," *JAMA* 307, no. 12 (March 28, 2012): 1263.

[26] Ibid., 1264.

subjective information about patients into an objective format changes the physician's opportunity to listen to a patient story into a data gathering exercise.

Electronic Communication With the Patient

Numbers and data constitute the electronic medical record used by the healthcare team, but they also can be shared with patients as a means of communicating information about diagnosis and treatment plans. Some APOMM writers advocate use of data technology in practice, albeit few in number. Dr. James Kahn gives his email address, office telephone, office fax and cell phone numbers to patients, and believes in the benefits of texting with them to share information.[27] He writes in 2012 about concerns related to information sharing, including HIPAA (Health Insurance Portability and Accountability Act) laws regarding protected health information, and confirmation of patient identity in calls or texts. Despite these issues, Dr. Kahn believes,

> Using technology is a way to reassure a person that they can self-direct their care, and self-directed care based on knowledge and understanding leading to insight is a powerful moment. I want my patients to be passionate about their health information and their health. Technology can help engage patients, provide access to information, and help them understand the implications of their information. When I empower my patients and help them understand their health situation, then I have been successful as their physician. I realize that in the end technology is not a replacement for empathy, expertise, kindness, or even human connections. But technology can help.[28]

Dr. Kahn considers providing information to patients a measure of his success as a caregiver, while acknowledging such exchange is not equivalent to speaking with them face-to-face. He, more than most of the other APOMM authors writing on this subject, seems to achieve a balance between the advantages and disadvantages of using

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[27] James S. Kahn, A Piece of My Mind, " Next: Text," *JAMA* 307, no. 17 (May 2, 2012): 1807-08.

[28] Ibid., 1808.

technology in his relationships with patients. Sharing information electronically adds to the doctor's means of communication with patients, complimenting his understanding and sensitivity towards them.

Electronic communication via texting is not equivalent to use of the EMR in practice, and this column differs from the others since it describes a separate facet of electronic data management in medicine. Dr. Kahn writes about an area of electronic technology that pertains to sharing information with patients, whereas the EMR is generally a tool primarily used amongst healthcare professionals.

The Computer as a Distraction in Patient-Physician Relationships

Gathering and maintaining clinical data can eclipse physician interaction with patients. One APOMM author creatively uses an effective visual representation to show the impact of the EMR in her group practice. Dr. Elizabeth Toll is a pediatrician and shares a revealing crayon drawing of an examination room made by a seven-year-old patient. The child in the picture sits on the examination table, but the doctor's face is turned away from the little girl, as he leans over a computer keyboard. The doctor depicted is Dr. Toll's associate; she speaks glowingly about his skill and demeanor with patients, while acknowledging the young patient's artistic and accurate perception of the doctor's lack of attention, favoring the computer instead.[29] The distraction created by the use of the electronic medical record in the intimate setting of the examination room is obvious. Dr. Toll explains the critical importance of the patient-physician relationship as a healing influence, and goes on to say,

[29] Elizabeth Toll, A Piece of My Mind, "The Cost of Technology," *JAMA* 307, no. 23 (June 20, 2012): 2497-98.

> When a physician focuses on a patient with complete attention, this simple act of caring creates a connection between two human beings. . . This connection between people is also one of the great satisfactions of our profession. . . This human connection has always been a central tenet of the patient-doctor relationship and that mysterious process called healing.
>
> But now the computer has entered this timeless dynamic as a third player. . . We must pick and click according to the EMR's pathways, rather than by following the patterns of learning and thinking we have internalized over years of training and practice. All this searching and selecting takes time, a lot of time. Not surprisingly, we find ourselves entering more and more data while we are trying to listen to and talk with our patients.[30]

Dr. Toll echoes Dr. Wellbery (cited earlier in this chapter) about the special nature of the patient-physician relationship as the shared experience of two people, considering electronic record keeping an intrusion on that unique engagement. She writes of the need to preserve the patient-physician relationship as a "sacred trust," despite the demands of electronic data gathering in medicine.[31] Dr. Toll ends optimistically, writing, "If we take time to connect with one another and draw strength from listening, learning, teaching and caring we can join together to find ways to take on new challenges, including the electronic medical record."[32] Dr. Toll seems to be rallying her colleagues to take action, sounding more positive than other APOMM authors too frustrated or fatigued to manage the challenge of computerized medicine.

Privacy of Patient Data

Once the data are gathered, maintained, interpreted and shared, how are they protected? A key element of data management is data privacy. The desire for large

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[30] Elizabeth Toll, A Piece of My Mind, "The Cost of Technology," *JAMA* 307, no. 23 (June 20, 2012): 2498.

[31] Ibid.

[32] Ibid.

repositories of data, and broad access to that data to facilitate patient care, comes with associated risks to patient privacy, a hallmark of the patient-physician relationship. Medical records maintained in paper form are typically stored in doctors' offices, clinics, in the medical records departments of hospitals and eventually at off-site storage locations. Staff members at each of these locations have access to the records, and patient privacy is paramount. Electronic records, on the other hand, exist in various forms, and staff both on-site and in remote locations have access to electronic files if they have authorization, while unauthorized users may gain access by breaching security systems.

The words of an early APOMM author regarding electronic records (then in their infancy in medicine) were in defense of patient privacy as a crucial feature of the patient-physician relationship. In 1987, Dr. Jeffrey Zaks presciently wrote about a risk of computerized medicine. As a patient advocate, he observed, "The completeness of the time-honored history and physical is interwoven with the absolute belief by both the patient and physician that an unspoken bond of uncategorical confidentiality is in effect and no judgment is forthcoming. . ."[33] Dr. Zaks expressed concern about expanded access to patient records wrought by electronic data gathering and management in healthcare, and the related risk to privacy of patient information, asking: "How many of these people have been given actual permission to be so honored as to know our patients' medical history? Has the computerized chart relegated the privacy and trust to which we are all entitled to the backseat of a floppy disk?"[34] The doctor accurately predicted the transformation of patient privacy from an entity largely between patient, physician and

[33] Jeffrey M. Zaks, A Piece of My Mind, "True Confessions," *JAMA* 257, no. 6 (February 13, 1987): 836.

[34] Ibid.

limited personnel, to a more intangible feature of electronic systems where more and more information is stored in computerized databases accessible to large numbers of healthcare professionals who share the data. An oversimplification of his concern is that in modern medicine, both patients and physicians are asked to trust the data systems instead of simply trusting each other.

A decrease in trust affects the quality of patient-physician relationships. Dr. Zaks focused on privacy as an element of the physician's responsibility to protect the patient. Caring for the patient involves protection from physical harm by illness, unintended harm by treatment, and harm from confidentiality failures involving precious information entrusted to the doctor. Privacy concerns are critically important, especially when data are stored in repositories accessible to multiple users repeatedly over time. While the risk of security breaches involving patient data is not a new phenomenon, modern electronic data storage involves such risk on an order of magnitude likely not anticipated when computers first entered daily life and later became essential in day-to-day activities. Patients need to trust that their health information is protected. Without trust between patient and physician, their therapeutic relationship is diminished.

* * *

The APOMM columns about the effects of data gathering and sharing technology in the medical world are a microcosm of the same effects in general society. Electronic systems command time and focus from the user, and replace much former person-to-person interaction in many daily activities, across all generations. Electronic data acquisition, transaction and storage are part of every-day life, including healthcare. The

expansion of such methods and systems is considered a cultural influence on caregiving for purposes of this dissertation. The columns examined in this chapter address the implications of data collection and use on patient-physician relationships, and consequently on expressions of the medical humanities in practice.

User proficiency with electronic data gathering and transaction is variable. Some APOMM authors who have practiced for long periods admittedly struggle to embrace the changes dictated by electronic data use, while younger authors sound less resigned and perhaps more energetic about the challenge of working in electronic environments. The handwritten medical note or record may someday be obsolete, and future APOMM columns will reveal whether the criticisms of the EMR and technologic data management remain consistent among practicing physicians choosing to tell their stories.

Electronic information gathering systems make vast amounts of data readily accessible to users. But the APOMM authors who write about data gathering and management in medicine argue that when such volume, access and speed are applied to the understanding and care of patients, more is not always more. Collecting data instead of writing the patient's story does not necessarily translate into knowing the patient's circumstance thoroughly and accurately, or to more physician satisfaction. Some writers prefer conversation to scientific data gathering when learning about patients, while others describe their efforts to find a place for both the art and science of medicine in their practices.

The columns in APOMM about the effects of electronic data gathering systems and conventions now engrained in much clinical care are multi-purpose. They are cautionary for medical students and younger practitioners accustomed to computerized

information access and exchange in everyday life. The authors remind readers that human beings are more complicated, more nuanced, and more unpredictable than the electronic caches of their health information. Readers are encouraged to understand data as an essential adjunct to the patient's story.

One could argue that writing the clinical note took the doctor's attention away from the patient, but several APOMM writers sound nostalgic about the practice. Their writing suggests they felt more present in their interactions with patients, and acquired greater understanding of the patient and the person, while making handwritten notes. Many of the APOMM physician-writers believe entering data into the EMR commands too much of the doctors' attention, limiting focus on the patient. Perhaps other users have mastered entering data into the EMR while engaged with patients, and their stories may appear in future APOMM columns. Meanwhile, regardless of their sentiment about electronic data gathering, management, and use in medicine, the APOMM authors consistently address the technology in terms of its effect on the patient-physician relationship.

The last chapter of this dissertation is about the influence of becoming a patient on doctors' understanding of the patient-physician relationship. APOMM authors who experience illness share what they learn about the sick role with colleagues.

CHAPTER FIVE

WHEN PHYSICIANS BECOME PATIENTS: NEW UNDERSTANDING OF THE PATIENT ROLE AND PATIENT-PHYSICIAN RELATIONSHIPS

This chapter is about the writing of APOMM authors concerning their experiences as patients (referred to here as physician-patient[s]). The writers share personal fears, details about their health, and the implications of illness on their professional lives, while describing key elements of patient-physician relationships from the patient perspective. The APOMM authors sometimes explain how being a patient changes both the way they approach patients and practice medicine afterward. The columns are stories about understanding and compassion shown to physician-patients, by their own doctors.

The definition of the medical humanities from the Division of Medical Humanities in the Department of Medicine at the New York University School of Medicine cited in Chapter One comes to mind, in this chapter about physicians as patients. It reads, in part, "The humanities and arts provide insight into the human condition, suffering, personhood and our responsibility to each other."[1] When this idea is applied to doctors' experiences as patients, their stories explain the medical humanities in particularly remarkable ways.

Approximately forty-four columns (published between 1982 and 2016) were considered for inclusion in this chapter; nineteen are referenced as especially representative stories about physicians as patients. The writing by physicians cited in the

[1] NYU School of Medicine, NYU Langone Medical Center, Division of Medical Humanities, Department of Medicine, "Literature, Arts, and Medicine Database," *About The Database*, Humanities, Social Sciences & The Arts in Relation to Medicine & Medical Training, accessed February 12, 2017, http://medhum.med.nyu.edu/about.

preceding chapters about various influences on understanding patient-physician relationships culminates in this chapter. The purpose of the doctors' writing changes from how they felt as physicians in relationships with patients to how they perceive their own situations and their own doctors when they become patients. The patient experience is a subject of regular interest to APOMM writers over the course of the column's publication.

Arguably, physicians who have not been patients lack a critical understanding of the role. The best way to learn about being a patient is to be one. Patients respond to physicians individually and sometimes unpredictably, and becoming a patient is self-revealing for the physician-writers. They describe bewilderment from newly diagnosed diseases or unexpected test results, and the challenges of living with acute or chronic conditions; they reach out to their medical colleagues from the physical and emotional confines of illness to express thoughts about becoming patients.

The APOMM essays by physicians are pathographies in miniature. The term pathography typically applies to book-length biographies dealing with illness experiences. Anne Hunsaker Hawkins writes on this subject and claims that, "Pathographies not only articulate the hopes, fears, and anxieties so common to sickness, but they also serve as guidebooks to the medical experience itself, shaping a reader's expectations about the course of an illness and its treatment."[2] The APOMM columns similarly reveal patient expectations, emotional responses to various phases of diagnosis and treatment, and insight into the physical and psychological outcomes of the illness experience. Authorship of these pieces by physicians makes them particularly informative for physician readers.

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[2] Anne Hunsaker Hawkins, "Pathography: patient narratives of illness," *Western Journal of Medicine* 171 (August 1999): 127.

Perception of the Physician Role When Becoming a Patient

Doctors writing about personal illness adventures pierce the physician veneer, allowing emotional and philosophical observations to flow. Stories about illness by APOMM authors range from minor to major procedures, from good outcomes to bad prognoses. Some authors write about their generally uneventful medical illnesses or surgical procedures while some detail complicated clinical courses. The doctors write about acute and chronic illness, and some write of their impending deaths. The scope of writing allows readers inside the minds of doctors sharing private, intimate details about the sick role from the physician-patient perspective.

Navigating the physical and psychological demands of being a patient in the broader context of personhood poses challenges to people who become injured or sick. Daily physical routines are disrupted by the need for outpatient visits or hospitalization, medications, physical therapy and other treatment-related appointments. Professional identity is threatened as well. This is the subject of some APOMM authors who explain that the loss of professional identity they experience is as great as the physical effect of illness.

In one column, Dr. Marlis Beier, writing in 2001, details her physical symptoms and increasing limitations from multiple sclerosis. Despite her physical challenges, Dr. Beier writes, "The loss of my relationships with patients has been the hardest. . . Everywhere I go in my town are people who have shared intimate times with me."[3] The reader is reminded of Dr. David Loxterkamp's columns about the personal and professional benefits he feels from living in community with his patients (see Chapter

[3] Marlis Beier, A Piece of My Mind, "Visiting the Sadness," *JAMA* 285, no. 19 (May 16, 2001): 2425.

Two). In the midst of losing physical strength and mobility, and her professional routine, Dr. Beier identifies her relationships with patients as her greatest loss.[4] Her physician role defines her, yet she is forced to cede to an illness she cannot manage as a doctor, but faces as a patient.

In becoming patients, some physicians find new meaning in their professional identities. Dr. Elizabeth Gay, a resident receiving treatment for sight-threatening diabetic retinopathy writes,

> I would prefer the threat of death to that of blindness. Reading for me seems as essential as breathing, as impossible to live without. And there is this: What if I can't do the job I've been working toward for eight years? But it is more than that because it's somehow become more than a job: it's become who I am. I am afraid that if I can't be a physician, I will lose my self.[5]

For patients like Dr. Gay who consider their physician role (or any role) as self-defining, illness poses a threat on both personal and professional levels. The story is a caution to readers about the potential effects of illness on professional identity, especially for practitioners strongly invested in their physician roles.

Inhabiting the world of sickness as a physician-patient places a doctor in a challenging position. One column exemplifies the shift between the caring role and sick role for doctors who are patients. The author, Dr. Natalie Mariano, is receiving radiation therapy for breast cancer. She describes in detail the rituals she follows each morning as she arrives, undresses, dons her gown and enters the treatment room. The focus of her 2002 column, entitled "The Changing Room," is the change she undergoes each day from physician to patient and back to physician, represented by her change from street clothes

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[4] Marlis Beier, A Piece of My Mind, "Visiting the Sadness," *JAMA* 285, no. 19 (May 16, 2001): 2425.

[5] Elizabeth B. Gay, A Piece of My Mind, "Insight," *JAMA* 303, no. 3 (January 20, 2010): 205.

to gown and back to street clothes.[6] She writes of the experience, "I shudder, not sure whether it's from the cold or from the shock of seeing the transformation of a physician, confidently caring for the sick, into a patient, self-consciously hoping she's dressed in a garment with no holes in places she cannot see."[7]

Dr. Mariano moves between the physician and patient world each morning, and the precise observations she makes of the waiting room, changing room and treatment room are revealing not only of the physical environment and experience, but also the intellectual and emotional spaces they signify to her. The study in contrasts gives readers a way of understanding the balancing act patients perform while enduring illness as a part of their lives. In a similar way, another APOMM author, Dr. Nir Lipsman, writes about what he observes when he pulls open curtains in treatment areas to meet patients, in his column entitled "Curtains," previously cited in Chapter Two.[8] His description of being outside in his professional space, and then entering the patient space, can be compared to Dr. Mariano's personal experience of moving between the physician and patient world.

A theme of the APOMM writing in this chapter is loss and gain. Physician-patients, like other patients, lose not only health and control, but a daily routine involving role/job/profession as well. Doctors who become patients additionally lose the perception of training-induced mastery over illness. Their clinical education affords them skills in problem-solving abilities and solution-oriented approaches to health challenges. However medical training does not prepare doctors to be patients. The authors regularly confirm

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[6] Natalie A. Mariano, A Piece of My Mind, "The Changing Room," *JAMA* 288, no. 17 (November 6, 2002): 2091.

[7] Ibid.

[8] Nir Lipsman, A Piece of My Mind, "Curtains," *JAMA* 302, no. 17 (November 4, 2009): 1845.

that while they may be highly educated professionals, they are struck by the realization that such advantage does not necessarily mitigate the effects of illness and associated loss.

Learning About the Patient Role

The doctors writing in APOMM identify with their patients in ways they were unable to before their illnesses. Their revelations come in a variety of tones. Some APOMM authors are somber, writing in defense of fellow patients struggling with illness. Some writers use a lighter approach to argue on behalf of patients and their needs.

One APOMM column is about the credibility a nephrologist earns with his patients as a kidney stone patient himself, working in a kidney stone clinic. Dr. David Goldfarb writes in 2013, lending credence to what he thinks are the sometimes-minimized complaints of fellow patients. When they tell their stories in emergency departments, while earnestly seeking narcotic relief, they can be labeled drug seeking by healthcare professionals.[9] Dr. Goldfarb's is a defense of patients he thinks deserve understanding and appreciation for what they experience, often repeatedly, as kidney stone formers. He explains how his stones enhance his relationships with patients:

> I could not foresee that several fortuitous events would make it possible for me to become the director of a kidney stone clinic, though my only credential then was having had two stones. That credential, though, would go a long way. It would hearten my patients, who would often gasp is surprise when they learned of our shared experiences and my first-hand familiarity with their travails. It would help me to elevate kidney stones beyond "cocktail party nephrology." I would try to get stones the recognition and respect deserved by a painful, humiliating, and expensive medical disorder with real consequences.[10]

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[9] David S. Goldfarb, A Piece of My Mind, "Cocktail Party Nephrology," *JAMA* 309, no. 24 (June 26, 2013): 2562.

[10] Ibid.

Dr. Goldfarb champions the plight of his patient comrades, establishing relationships with them in his office, and advocating for them to readers of his APOMM column. He indirectly reaches out to patients by writing to their doctors, his colleagues, to enlighten them via his column.

The story above is about validating the patient experience, from the perspective of how the patient is understood when seeking medical care. Another factor in the patient experience involves what a patient hears and what a patient comprehends since they may differ. Not only is it critical that doctors communicate information; such communication must be conducted with patience and insight, showing understanding in the patient-physician encounter. Dr. Marion Block addresses these issues when she relates her newfound grasp of patient circumstance during her own breast biopsy. Dr. Block writes in 1987, about the realization that she has used the words she hears from her surgeon with her own patients, and how suddenly lacking they sound.[11] The surgeon says, "I guess I have to say this, but you're going to be all right. If this is breast cancer, it's the earliest kind we know."[12] Dr. Block describes the surgeon as "the most trustworthy I know, someone kind and thoughtful, a superb clinician, a good communicator."[13] Yet as the patient, she is unsettled and made anxious by his words. After her procedure she explains,

> In the context of having the best care for a minor surgical procedure, I marvel at what my patients must go through. How are my words understood? How many questions go unasked? . . Now I understand their feelings: it is impossible to separate the trivial nature of the surgery itself from its catastrophic implications.[14]

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[11] Marian R. Block, A Piece of My Mind, "The Bad News," *JAMA* 257, no. 21 (June 5, 1987): 2959.

[12] Ibid.

[13] Ibid.

[14] Ibid.

Her doctor's words change Dr. Block's understanding of what her patients need to hear from her. A doctor's language, intended to inform and calm the patient, may have the opposite effect. Dr. Block's mass is benign, and another positive outcome of her procedure is a better appreciation for the patient experience. She reminds colleagues of the power of their words.

A slightly different perspective on what people hear comes in a story from Dr. Sondra Crosby, writing as the physician mother of two daughters with multiple health issues adopted from Sierra Leone. She describes all of the testing done for her children in medical terms, and then writes,

> My head often spins from receiving so much information. Because I am a physician, other medical professionals seem to assume I have a complete understanding of all of our girls' medical conditions and am therefore capable of making informed decisions. This clearly isn't the case. Objectivity is blinded by parenthood, and I often leave a physician's office feeling confused and scared, trying to remember what was said, and always questioning whether I am making the right decisions.[15]

Dr. Crosby's words tell readers that being a physician does not prevent her from being overwhelmed when her children are the patients. The presence of such stories over the course of APOMM publication affirms the value of sharing personal experiences about physician citizenship in the patient world.

Learning About Fear

While most patients fear the unknown, fear of the known is an additional burden for doctors as patients. They contemplate the diagnoses suggested by a particular cluster of symptoms they experience, sometimes before they seek help. They know the language

[15] Sondra S. Crosby, A Piece of My Mind, "A Mother's Prayer," *JAMA* 283, no. 9 (March 1, 2000): 1109.

of medicine and can interpret test results. They know what proposed treatment will involve in greater detail than lay patients. This knowledge base of the physician-patient can complicate the patient experience, and may add to the fear implicit in that role. When doctors becomes patients, they have more to worry about because they cannot unlearn what they know about the human body, and the physical, psychological and emotional response to illness. For example, Dr. Steven Frank writes in 1984 about his fear when he finds an axillary mass, convincing himself he must have Hodgkin's lymphoma, based on his education as a physician.[16] He sounds simultaneously frightened by not knowing what is happening, and by what he knows may happen. He also admits that despite receiving care from colleagues he knows and trusts, as a patient, he feels the indignity of wearing a hospital gown and surrendering to hospital policy concerning pre-operative procedures.[17]

A biopsy reveals a benign mass. Dr. Frank writes of his experience,

> I also learned some valuable lessons. All the people I'd seen that day I'd worked with on major cases. I had known their level of competence. Yet, even though it turned out that my surgery was so minor I probably could have done it myself, I had been terrified. I later thought of how it is with sick patients who must face surgery alone, among strangers whose competence and kindness have yet to be proved. I hope I never forget it.[18]

The author focuses on the benefits of his jarring experience, especially since his is a good outcome. He learns how much he shares with other patients: uncertainty, invasion of privacy, loss of control, anxiety and blind trust are part of the patient experience. Dr. Frank's column is about appreciating the patient role, with an acquired awareness he hopes to retain.

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[16] Steven E. Frank, A Piece of My Mind, "Lessons," *JAMA* 252, no. 15 (October 19, 1984): 2014.

[17] Ibid.

[18] Ibid.

Unlike fear of the known as a unique problem for physicians as patients, doctors share fear of the unknown with all patients. A number of the APOMM authors admit their heretofore-unrealized fear of general anesthesia as first-time surgical patients requiring such sedation. One doctor writes openly about her concerns, despite her medical training, when she is scheduled for a lumpectomy for breast cancer. Dr. Ellen Feld's fright is alleviated by the relationship that quickly develops with her anesthesiologist, someone she perhaps had not met until a few minutes before induction for her procedure. She writes, "The anesthesiologist is kind, gentle, and funny. By the time my IV is in, he's managed to reassure me about most everything . . . His bedside manner is magic: as they wheel me toward the OR [operating room], for the first time since my diagnosis, I am worry free."[19] In this essay, the development of a patient-physician relationship happens quickly and allays the patient's fear. Dr. Feld's outcome is good; her nodes are negative for tumor and the story ends happily.[20] She writes her column about the various and overwhelming anxieties she experiences when she becomes a patient, validating such feelings for her readers. She is surprised both by the magnitude of her fear, and the rapidly soothing effect of her doctor's approach and words.

Stories like those described above remind doctors it is all right to be afraid, and to expect such fear in patients. The columns teach readers that being a doctor is not necessarily an advantage when becoming a patient. In fact, some of the columns suggest that medical knowledge may be a disadvantage to physicians who become patients.

Revealing personal thoughts and especially fears about the sick role is a brave gesture on the part of any author. Sharing such fears with readers is an intimate act, and

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[19] Ellen D. Feld, A Piece of My Mind, "Worries," *JAMA* 308, no. 9 (September 5, 2012): 874.

[20] Ibid.

places the author in a vulnerable position relative to interpretation and judgment by readers. The APOMM authors take even greater risk with their columns, knowing their colleagues may judge them by professional as well as personal standards relative to patient behavior. This is especially true of the physician-writers who disclose their psychiatric illnesses in APOMM, examined later in this chapter.

The Importance of Information

Some of the APOMM authors write about their need for information as a corollary to their fears. While medical knowledge may not always be an advantage to physician-patients as discussed above, most patients want information about their situations. In addition to fear about so many facets of the patient role, patients who write about their experiences often express their need for information. Amanda Redig writes as a medical student in 2006. She undergoes months of testing for a chronic pulmonary condition and her theme is the stress of uncertainty that comes with illness. She explains the unique and critical nature of personal communication between physician and patient.[21] She confirms that such communication is paramount, writing, "I will never be able to forget that it is, far more so than the positive prognosis or pronouncement of a good outcome that are often mistakenly assumed to matter most. Patients may want good news from a physician, but what we need is news, period."[22] Redig advocates for other patients, saying, "What matters here, in this place of feeling sick and tired and sometimes

[21] Amanda J. Redig, A Piece of My Mind, "Jigsaw," *JAMA* 295, no. 4 (January 25, 2006): 363-64.

[22] Ibid., 364.

scared, is when the person who knows what is happening takes the time to make sure that I do too."[23] The patient's need for information is key to the patient-physician relationship.

We humans fill empty places of our understanding with imaginative outcomes every day. But when the setting of illness is where the empty places reside, our conjured scenes become especially frightening and isolating, often involving worst-case scenarios. Anyone who has awaited biopsy results knows this feeling intimately. Days seem to never end when waiting for news of whether life will continue as before, or be altered or perhaps threatened. The prolonged days of uncertainty and attendant anxiety can sap the strength of the strongest patient and family. Redig captures this feeling in her observations. Later, when she is once again working, she notices how her approach to patients has changed, explaining that as she examines a patient, hesitating when she feels a questionable lymph node, she stops to tell the patient that it is a normal finding, sensing the patient's anxiety: "It wasn't until I saw the fear lurking behind her eyes that I realized I knew what I was looking for – but she didn't. And, even more than her disease or discomfort, that uncertainty made a difference."[24] Redig is aware of modifying her approach to patients as a result of her personal experience. She fills the gap in her patient's understanding of what is happening. The themes of her column for her colleagues are respecting anxiety borne of waiting for information, sharing information by communicating clearly and showing sensitivity to patients.

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[23] Amanda J. Redig, A Piece of My Mind, "Jigsaw," *JAMA* 295, no. 4 (January 25, 2006): 364.

[24] Ibid.

Stories of Psychiatric Illness

Three columns from APOMM authors concerning psychiatric illness are included here. All three authors endure the occupational hazard of knowing what is happening to them, and sensing the attitudes of their colleagues towards psychiatric illness. These factors inform their understanding of fellow patients.

Doctors revealing their psychiatric diagnoses, and addressing the stigma of psychiatric disease within the medical community, risk judgment in their professional and personal lives. The first APOMM column, written in 1998 by Dr. Steven Miles, details his emotional and professional experience after disclosing his diagnosis (type II bipolar disorder) during relicensure.[25] He also mentions the suicide of a medical student at his institution: "It was rumored that he feared career stigmatization from using mental health care."[26] Dr. Miles recounts dealing with actions and decisions of his state's licensing board, the American Psychiatric Association and the federal government, while earnestly explaining the need for treatment of physicians with psychiatric disorders in a population fearful of seeking help lest their careers be jeopardized.[27] He speaks to his colleagues in his column, ultimately for the benefit of patients. Dr. Miles writes:

> The medical profession would benefit from competent colleagues who were comfortable discussing their mental health care. They would help erase the prejudices that arise when seeking such treatment is stigmatized or when mental illness is visible only after a catastrophe. I am delighted that medical school counselors say that students have cited my public challenge to the Board as they sought help. If we could speak openly with each other, physicians could teach physicians who have not experienced depression how to better diagnose and treat this disease. Though I would not wish the pain of depression on anyone, I am a

[25] Steven H. Miles, A Piece of My Mind, "A Challenge to Licensing Boards: The Stigma of Mental Illness," *JAMA* 280, no. 10 (September 9, 1998): 931.

[26] Ibid.

[27] Ibid.

> better physician for my experience, more empathic with this pain, and better equipped to sustain my patients.[28]

In the midst of his personal struggle, Dr. Miles seeks to improve his colleagues' understanding of his diagnosis. The authors of the stories about psychiatric illness share two themes: the desire to enlighten other physicians about psychiatric illness, and their increased understanding of patients in general, and those with psychiatric illness in particular.

In 2004, Dr. Suzanne Fiala writes about her bipolar disease. She explains her wish to eliminate the stigma associated with psychiatric illness and treatment, prompted by her desire to change the world for her children, especially since hers is a family with a history of psychiatric illness.[29] She writes, "Normal is a place I visit, not one in which I am allowed to remain."[30] Dr. Fiala echoes Dr. Miles when she describes gaining heightened patient sensitivity as a result of her personal illness:

> Some aspects of being a good physician are enhanced.The illness has given me a compassion and sensitivity for others that has made me a better doctor. Being personally intimate with pain and suffering has been translated into an ability to reach out to my patients at a deep level of connection and caring. My experiences with the extremes of emotions make me feel more in touch with the joys and sorrows of being human.[31]

Relationships with colleagues and patients are at the center of the stories in this section. Eleven years after Dr. Fiala's column appeared, Dr. Quinn Leslie writes while a resident in 2015, about her diagnosis of bipolar disorder during medical school. The

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[28] Steven H. Miles, A Piece of My Mind, "A Challenge to Licensing Boards: The Stigma of Mental Illness," *JAMA* 280, no. 10 (September 9, 1998): 931.

[29] Suzanne J. Fiala, A Piece of My Mind, "Normal Is a Place I Visit," *JAMA* 291, no. 24 (June 23/30, 2004): 2924.

[30] Ibid.

[31] Ibid., 2925.

author discloses her experience to readers (fellow students and future colleagues), explaining, "Without realizing it, I matured into the empathetic physician I always hoped I would be - if nothing else I would always understand how it felt to be sick and scared and just to need someone on your side."[32] The doctors writing about psychiatric diagnosis and treatment explain the negative aspects of their experiences, describing what they see as the profession's lack of understanding. Yet they stress to readers that despite their diagnoses and disappointments, they are stronger and more capable of understanding and caring for patients as a result.

Becoming a Physician-Patient Due to Occupational Exposure

The candor of physicians writing about their own illnesses for their colleagues comes in various forms. Thus far in this chapter, referenced authors describe what they learn from both physical and psychiatric illness. One column is an anomaly among the others, by a doctor who becomes a patient because of a patient. Dr. Malinda Bell receives a needlestick injury: "The patient was drunk, uncooperative, and HIV positive. He was also my 'donor' for an occupational bloodborne pathogen exposure, a stranger who previously had a life entirely separate from mine, but temporarily needed my help, and who might now be with me for the rest of my life."[33] This is a rare column about practicing medicine; the doctor describes her mixed emotions of wanting to help patients while realizing that helping could bring her personal and professional harm.

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[32] Quinn Leslie, A Piece of My Mind, "Take a Look at Me Now," *JAMA* 313, no. 2 (January 13, 2015): 138.

[33] Malinda H. Bell, A Piece of My Mind, "Blood Lines," *JAMA* 283, no. 23 (June 21, 2000): 3043.

Dr. Bell's column is an accounting of her thoughts as she completes her workday, begins the process of documentation and treatment for her injury, voices fears for herself and her family, and waits for her test results.[34] Her relationship with the patient changes at the moment of exposure to his blood. The patient appears in the second and third paragraphs of Dr. Bell's column and then disappears from the page, crowded out by her anxiety about the personal and professional ramifications of a possible conversion to HIV positivity. Her one-month and three-month test results are negative, and the APOMM editor shares in a postscript that Dr. Bell's six-month test is also negative.[35] Dr. Bell, like Dr. Pius Kamau (see Chapter Three) expands reader understanding of how complicated the patient-physician relationship can be for physicians who are either potentially or actually threatened by providing care. These doctors articulate infrequently expressed (in APOMM columns) emotions about patients, and editorial selection of the columns suggests their messages are considered important for the readership.

Commonalities of the Patient Experience

Doctors who become ill tell stories in APOMM about newfound understanding of what they share with other patients. In one example, a doctor tells of minimizing his symptoms to himself, subconsciously attempting to avoid becoming a patient.
In 2012 Dr. Cornelius Gropp details the symptoms he eventually diagnoses correctly as a side effect of his statin therapy. He realizes,

> Moreover, we physicians might be harsh in our judgment of our patients' negligent self-care or poor adherence while we might treat ourselves in similarly cavalier ways with regard of our own welfare and well-being. One reason for that

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[34] Malinda H. Bell, A Piece of My Mind, "Blood Lines," *JAMA* 283, no. 23 (June 21, 2000): 3043.

[35] Ibid., 3043-44.

> is perhaps that after listening to so many accounts of pain, sorrow, anguish, and disaster, we crave self-reliance and control in whatever quarter we can in order to overcome the fear of our human frailty. We tend to imagine ourselves a class apart where health is concerned, and might drift to extremes in our own care, caring either too much or too little. Just like the patients we treat, we too easily skip large areas of conflict in our introspection, especially those we might be embarrassed to reflect upon.[36]

Dr. Gropp realizes how much he shares with his patients in his initial denial of symptoms, reinforcing for his readers that little separates physicians from patients in matters of health.

Dr. Alan Guttmacher organizes his column (published in 2000) about his experience as a patient into twenty lessons for his colleagues. His format is structured yet creative, and each succinct lesson engages the reader. Dr. Guttmacher experiences a heart attack (at age forty-nine) with loss of consciousness while asleep with his wife.[37] He writes of his subsequent, complicated hospital course. His lessons are for treating physicians, and those pertaining especially to patient-physician relationships are: "***Lesson 10: Always wonder, 'Why does* this *person have this disease?***,' and ***Lesson 12: All physicians become patients.***, and ***Lesson 17: In medicine, one size does not fit all. Treat the patient, not the disease.***"[38] The column is at times an entertaining tutorial: "***Lesson 1: Never sleep with anyone who doesn't know CPR.***"[39] Dr. Guttmacher's use of humor is relatively rare in APOMM. (Less than twenty columns, published between 1982 and 1994, are humorous, and the majority does not concern medicine).

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[36] Cornelius Gropp, A Piece of My Mind, "A Pain in the *Tuches*," *JAMA* 308, no. 23 (December 19, 2012): 2468.

[37] Allan E. Guttmacher, A Piece of My Mind, "Twenty Lessons From the Heart of Medicine," *JAMA* 284, no. 12 (September 27, 2000): 1486-87.

[38] Ibid.

[39] Ibid., 1486.

Patients knowingly or unknowingly seek to make meaning of their illness experiences, and such meaning can serve as another lesson for APOMM readers. Dr. Elizabeth Gay (referenced earlier in this chapter) is a physician writing retrospectively, in 2010, about her life with diabetic retinopathy. She credits a skilled ophthalmologist with restoring her dimming vision, knowing this may be only a temporary reprieve.[40] Dr. Gay ends her column describing the camaraderie she has with other patients, despite her physician perspective. She shares, "I am like my patients, like all survivors of illness, left with gratitude and uncertainty, wonder and fear."[41] Dr. Gay captures the often humbling effect of illness on many patients, including physicians often focused on restoring wellness, who then become patients themselves.

Learning the Importance of Time With the Physician

As described in the previous chapters, time with the doctor is important for patients and contributes to developing therapeutic patient-physician relationships. Time feels altered during illness experiences. Hours stretch when a patient is waiting for pain relief, or waiting for a diagnosis. The time patients spend with a doctor may bring some respite from uncertainty, whether the news eventually is good or bad. Time is also therapeutic as explained by one APOMM author. Dr. David Worthen addresses the importance of time with his doctor, writing in 1987 of his new diagnosis of amyotrophic lateral sclerosis (ALS). He explains, "As the patient, I find that the second-to-second hurt of living the diagnosis contrasts with the episodic pain of the physician's declaring a diagnosis, then walking away. As a physician, I have come full cycle: I live both sides of

[40] Elizabeth B. Gay, A Piece of My Mind, "Insight," *JAMA* 303, no. 3 (January 20, 2010): 205.

[41] Ibid.

the diagnosis."[42] Dr. Worthen likens the brief visits from the doctor to "episodic pain," rather than a comforting presence.[43] He understands what is happening to him, including no hope of cure. Time is what his doctor can give, and what Dr. Worthen wants as a patient. While a physician may have no scientific treatment to offer, there is always the art of giving time and presence to the patient.

The columns from doctors becoming patients are not centered on diagnostic capabilities, treatment innovations, or improved clinical outcomes. Perhaps this is because the physician-writers tell their stories more as patients and less as doctors. They write about what they see as the art of medicine as they receive care, with a different understanding of what that means than before their illness experiences. Their subjects are patient fear, and the need for understanding, information and time from their doctors, and in the next story, the need for trust.

The patient's trust in a doctor is a cornerstone of medical care. Dr. Amanda Redig writes five years after her initial column, sharing another part of her complicated medical history and patient experience. She has completed medical school and writes as a physician in 2011:

> The truth of the matter is that patients tell physicians their secrets all the time. . . The thing about being a physician is that we may be more likely than anyone else in our patients' lives to hear all of their stories. There's something about the relationship between patient and physician that is, if not exactly sacred in the theological sense, remarkably close when it comes to the imperfect humanity with which we live our lives. And I don't think this changes when the patient is also a physician. There are things I've told my doctors that my best friends don't know, let alone my blood relatives.[44]

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[42] David M. Worthen, A Piece of My Mind, "Inside the Diagnosis," *JAMA* 258, no. 9 (September 4, 1987): 1225.

[43] Ibid.

[44] Amanda J. Redig, A Piece of My Mind, "The Patient's Patients," *JAMA* 306, no. 3 (July 20, 2011): 248.

Dr. Redig's likening of the patient-physician relationship to a sacred entity reinforces the reverence necessary for creating trusting encounters with patients.

Dr. Harold Jenkins addresses trust also, in an APOMM column from 2002. He writes about the changes in medicine he must keep abreast of during the ten-year periods between his emergency medicine recertification examinations, including new pharmaceuticals, new diseases and new technologies.[45] But his column really is about what the experience teaches him of trust and relationship, from the patient perspective. Dr. Jenkins shares,

> It's the inner hunch that after inching our way through yet another broad test of medical knowledge, we physicians are still incredibly blind to a critical area of professional skill – our ability to listen to and talk with our patient. . . [T]his is a medical skill – possibly the one that counts the most – that never makes it into a recertification examination.[46]

His thoughts on the subject are influenced by his experiences as a patient. He writes about his colleague caregivers,

> From the first, my visits to their examination rooms were as educational as any postgraduate review course. They reminded me – in both positive and negative ways – that the truly competent physician is the one who sits down, senses the "mystery" of another human being, and offers with an open hand the simple gifts of personal interest and understanding.[47]

The messages in the APOMM columns by physicians who become patients are quite simple when juxtaposed with the complexity of modern medical care. The important missives from the authors are not technologic, costly or difficult to provide when doctors are committed to patient-physician relationships. The writers speak to their

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[45] Harold S. Jenkins, A Piece of My Mind, "The Morning After," *JAMA* 287, no. 2 (January 9, 2002): 161-62.

[46] Ibid., 161.

[47] Ibid., 162.

colleagues, in effect saying: Patients are afraid. Speak to them. Be sincere. Patients need information. Tell them what is happening. Patients are people. Treat each patient as a unique individual; remember some day you will be one of them. Patients are complex. Be curious. Communication is more than verbal. Communicate sensitivity and compassion. Take time to comfort the patient with your words and clinical skills, but also with the unique skills you have as a fellow human being. Patients notice those skills in doctors, and when the skills are absent. Little separates you from patients; you are similar in more ways than you may have realized before you became one.

* * *

This final chapter examines the confluence of physician knowledge and practice with the patient experience, when doctors become patients. The columns span the publication period of APOMM, confirming the consistent decision of physician-patients to share their stories, and readership interest in observations from physicians who become patients. The writing is personal, from physician-writers sharing private thoughts and reactions to becoming physician-patients. Columns in Chapter Five are the corollary to those in Chapter Two; in the earlier chapter the doctors write from the physician perspective in the patient-physician relationship, but in Chapter Five they write as patients. The stories are individual lessons for readers in understanding the patient role, and in witnessing the humanities in medicine, from physicians reflecting on receiving, rather than giving, care.

CONCLUSION

The impetus for this dissertation was an interest in exploring the non-clinical physician storytelling in "A Piece of My Mind" (APOMM), a feature of the *Journal of the American Medical Association (JAMA).* The column was introduced in May 1980, and remains in publication today. The columns are personal narratives primarily written by physicians and medical students about medical training and practice. The authors are referred to as physician-writers.

All columns from May 1980 through April 2016 (totaling 1,438) were read, using *grounded theory* and the constant comparative method of qualitative analysis, developed by Barney G. Glaser and Anselm L. Strauss, as a general and informal guide.[1] Grounded theory involves deriving theory (in this case observations and conclusions about the APOMM columns as a collection) by analyzing and organizing data (each individual column), simultaneously.[2] Expectations about distribution of the columns by subject were not considered prior to reading. Instead, a classification of the columns emerged as more and more columns were read; five broad subject areas included columns about patients, medical practice, the medical humanities, personal subjects, and dying and death. All of the five categories included stories about patient-physician relationships, and these columns became the focus of this dissertation.

The thesis of this project is a two-fold claim about columns centered on patient-physician relationships: first, they are individual examples of the physician-writer's interpretation of the humanities applied to relationships with patients, and second, as a

[1] Barney G. Glaser and Anselm L. Strauss, *The Discovery of Grounded Theory: strategies for qualitative research* (New Brunswick [USA]: Aldine Transaction, 1967).

[2] Ibid., 43.

collection they are a resource of consistent and timeless interpretations of the medical humanities, demonstrating a broad range of physician interest in understanding and preserving the importance of professional relationships with patients.

The physician-writers see through the lens of their own impressions of the humanities in relation to medicine when telling their stories. As Dr. Edmund Pellegrino wrote in 1974: "Each encounter with a patient entails some intersection between the values of society, of the patient and of the physician."[3] Each author's views involve personal philosophy, psychology, ethics, faith, community, customs, life experience and professional experience. Every story thus becomes a constituent part of a body of work reflecting the medical humanities explained through personal perspectives. As such, the columns are a wellspring for readers interested in adding to their conceptualization of the medical humanities.

The chapters were organized to fully explore the scope of writing about patient-physician relationships. Chapter One introduced the reader to APOMM, setting it into the historical context of medical education, clinical physician writing and non-clinical physician storytelling in the twentieth century. Chapters Two and Three demonstrated physician-writer thought on factors that enhance, and diminish patient-physician relationships. Chapter Four explored the effect of data gathering and management on patient-physician relationships, particularly the influence of the electronic medical record. Chapter Five included stories from doctors who became patients. Chapters Four and Five showed the contrast between increasing, and potentially depersonalizing, technology in medicine, and the personal and primal experience of becoming a patient. In Chapter Two,

[3] Edmund D. Pellegrino, "Medical Practice and the Humanities," *NEJM* 290, no. 19 (May 9, 1974): 1084.

the physician-writers spoke from the physician perspective in patient-physician relationships, whereas in Chapter Five they spoke as patients. Through wide variety of approach, the APOMM authors demonstrate regular, ongoing commitment to understanding, explaining and improving physician relationships with patients.

Observations

At one time I thought the APOMM columns could be likened to clinical progress notes, where the patient's course is documented in the medical record, showing change over time. Interestingly, the theme of constancy rather than change emerged from reading all of the columns. Although some columns included select references to changes in medicine over the thirty-six years of publication examined (for example, changes in procedures and technology, increases in business influences), the consistent presence of columns about patient-physician relationships regardless of changes in medicine came to the fore. The columns are not like professional progress notes that show change, but rather personal notes about preservation of the patient-physician relationship *despite* change in medicine.

APOMM is a steady pulse of non-clinical writing about medicine for doctors, housed in a professional medical journal. The stories are about intimate exchanges between people, when those people are patients and physicians. The authors affirm the patient relationship as a touchstone of medicine, and sentiment from the early columns sounds very similar to sentiment expressed in more recent columns.

The APOMM columns are simple messages to readers practicing in the complicated, costly and sometimes contentious world of modern healthcare. The authors choose to share stories about both successful and unsuccessful interactions with patients,

writing regularly about the challenge to understand patients within the context of appreciating them as people. The messages in the columns often are about turning away from the many distractions (both interpersonal and technologic) that interfere in physician relationships with patients. Physician-writers describe incorporating listening skills, spending more time with patients, and purposefully learning about the patient, and the patient role, to fortify patient-physician relationships. Such practice blends the art of medicine with the science, yielding expressions of the medical humanities in stories from APOMM.

Recommendations

The APOMM columns can be considered an informal tutorial for medical students and practicing physicians. They show readers possibility in therapeutic encounters between patients and physicians. The columns are weekly installments in an ongoing project by artists (physician-writers) explaining the art of medicine to colleagues, and revealing human behavior when people join in the delicate dance of the patient-physician relationship.

Because the stories in APOMM are about relationships between people, they are valuable to non-physician healthcare professionals as well. Those training and practicing in clinical, teaching, research, bioethics and medical humanities settings could benefit from reading select columns. They offer unique insight into personal thoughts about training and practice in medicine, but because they reside in stories about patients, illness and the human condition, they are worthwhile for anyone aspiring to work in healthcare.

In a single resource, readers can learn about not only patient-physician relationships as examined here, but about a wealth of topics regarding medicine in

APOMM columns not included in this dissertation. The five categories that emerged from reading and classifying the columns for this project could serve as independent teaching modules. Additionally, there are columns about interactions with patients having specific diagnoses (for example, heart disease, lung disease, cancer), and author perspective on training versus practice (columns by medical students versus practitioners or retired practitioners). There are columns from physician-writers about military experience, and columns from doctors working in international settings. Many authors describe experiences related to the deaths of family members and their personal reactions to the deaths of patients. The writing is informal and practical, giving readers access to varied and valuable instruction in the art of medicine.

Lay readers could also benefit from reading select APOMM columns. The non-clinical writing provides physician thought, emotion and reaction to patient experiences perhaps not usually apparent to lay people, expanding an understanding of physicians' perspectives on their relationships with patients.

The length of the publication period and popularity of APOMM suggest that physician readers find value in the columns for their own practices. Perhaps some of the APOMM authors wrote columns years after being exposed to literature and medicine, medical humanities and narrative medicine during their training. The impact of such learning opportunities may have influenced physicians to become APOMM contributors later in practice. Similarly, today's readers of APOMM may be influenced to write their own columns about practice someday, continuing the writing tradition begun in 1980.

Limitations

One limitation of this work is the small sample size (99 columns) of APOMM writing, now in the thirty-seventh year of publication. Approximately 875 physician-writers contributed the columns read for this project, and weekly columns continue regularly in *JAMA*. The columns chosen, though limited in number, were intended as especially instructional examples of varying thoughts on patient-physician relationships.

My advisors for this project accurately observed that the APOMM physician-writers are a self-selected group. The decision to write about a relationship with a patient, or lack thereof, suggests author interest, motivation and commitment to the patient encounter and related physician responsibility, and it is not surprising that the APOMM authors champion the patient-physician relationship.

My interpretation of the columns is a recognized confound. Each reader interprets material differently, through the personal lens of professional and life experience. Other readers might make alternative observations or analyses of the columns chosen. This dissertation represents only my interpretation of the selected columns.

Space limitations affected this work. The references from the columns were chosen as particularly representative of each physician-writer's message and tone, including as much variability and distinction as feasible. However, the inclusion of a few sentences or paragraphs from a column cannot be compared to reading each column in its entirety. No disservice to, or misrepresentation of, writing by the APOMM physician-writers was intended.

Analysis of the APOMM columns includes acknowledging the role of the *JAMA* editorial staff in the selection process for publication. Just as the personal motivations of

the authors cannot be known, neither can the professional and creative intentions of the editors who choose columns for APOMM. No opinion about their choices is expressed.

* * *

Medical practice happens in one patient-physician relationship at a time. These relationships are the focus of this dissertation, and central to medicine. The stories in APOMM help readers understand how people get along in the unique interaction between patient and physician. They can serve as a mooring for physicians perhaps adrift in modern healthcare settings. Dr. Robert Laskowski writes in March 2016, using his column to explain the significance of relationships with patients:

> The current world of medicine is a dizzying spectacle of change. New visions of medical practice are emerging. Large groups of physicians have largely supplanted small group practice. Medical teams staffing medical homes are operationalizing new approaches to coordinate care. Electronic health records and myriad clinical protocols are systematizing medical practice. In the midst of this restructuring, it is very important that we do not inadvertently lose sight of the power of the relationship between patient and physician.[4]

While medicine has changed greatly since the start of APOMM, the columns remain regular and reliable. The rich, relationship-based stories are a counter to the many challenges of providing healthcare in 2017, offering constancy, and often focusing readers on patients, and the value of the patient-physician relationship. In fact, Dr. Laskowski's words apply to our world in general, where interpersonal connection and relationship is increasingly replaced with electronic communication and online communities. Physician-writers in APOMM share their perspectives on relationships between patients and physicians, but their stories also are about relationships between people.

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[4] Robert J. Laskowski, A Piece of My Mind, "The Power of 'My', " *JAMA* 315, no. 12 (March 22/29, 2016): 1235.

This dissertation demonstrates how the APOMM columns about individual understanding of patient-physician relationships form a collection of informal writing over time that illuminates understanding of the medical humanities. Each physician-writer's understanding of the humanities influences each caregiving encounter with patients, and each story in APOMM.

The alchemy in any patient-physician dialogue is a product of the infinite combinations of patient and physician opinion, attitude and perspective. Interactions between two people are inherently enhanced by human capability and creativity, while also potentially flawed by human failings. The outcome of each engagement is unknowable at the outset, and unpredictable depending on changing circumstances over time, making encounters with patients a puzzle for the physician. The APOMM columns explore the mystery of this special human relationship.

The APOMM authors, particularly those cited in this dissertation, write about their efforts to practice both science and art in medicine, in stories about the paramount importance of professional and therapeutic relationships with patients. Their individual and collective contributions stand as continuous and ongoing examples of how the humanities can inform the practice of medicine, centered on exploring, enhancing, protecting and preserving the patient-physician relationship.

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