

**Virtual Mentor**  
**American Medical Association Journal of Ethics**

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Docs Go Casual

**From the Editor**

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- Doctor Saving Time** 143  
Audiey Kao, MD, PhD

**Case and Commentary**

---

- Terminating a Patient-Physician Relationship** 146  
Commentary by Kayhan Parsi, JD, PhD

**In the Literature**

---

- Defining Ethical Problems in Medicine** 147  
Keith Bauer, PhD, MSW

**AMA Code Says**

---

- The Code as Expert Witness** 149  
Karen Geraghty

**State of the Art and Science**

---

- Taking Family Histories with Genetics in Mind** 151  
Faith Lagay, PhD

**Art of Medicine**

---

- Sketching the Role of Medical Illustrators: An Interview with JAMA's  
Cassio Lynn** 154  
Sara Taub, MA

**Personal Narrative**

---

- "Hey Doc! Something's Crawling Out of My Foot."** 157  
Robert Davidson, MD, MPH
- Moral Wounds: Complicated Complications** 160  
Faith Lagay, PhD

<b>"But I Don't Eat Sweets": The Puzzle of Patient Noncompliance</b>	<b>161</b>
Michael Bevins	

### **Viewpoint**

---

<b>Healing at the End of Life</b>	<b>164</b>
Bruce Bartlow, MD	
<b>Balls, Strikes, and VIPs</b>	<b>167</b>
Audiey Kao, MD, PhD	
<b>The Trend Toward Casual Address and Dress in the Medical Profession</b>	<b>169</b>
Sara Taub, MA and Kayhan Parsi, JD, PhD	
<b>Bac Si My: An American Doctor in Vietnam</b>	<b>172</b>
Karen Geraghty	

### **Upcoming Issues of *Virtual Mentor***

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June: Disparity in Health Care Delivery  
July: Medicine on TV  
August: Poets? Yes. Providers? No.  
September: The Difficult Patient-Physician Relationship

## *Virtual Mentor*

American Medical Association Journal of Ethics  
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### **FROM THE EDITOR**

#### **Doctor Saving Time**

Audiey Kao, MD, PhD

Except for those of us living in Hawaii, American Samoa, Guam, Puerto Rico, the Virgin Islands, Arizona (excluding the Navajo Indian Reservation), and the eastern time zone portion of Indiana, the ritual of setting our clocks forward one hour on the first Sunday of April is observed in homes and communities across the US. Though it dates back to an idea of Benjamin Franklin, Daylight Saving Time (DST) was not firmly established until passage of the Uniform Time Act of 1966.

Many of us accept losing an hour of sleep on the first Sunday of each April for the benefit of enjoying more hours of daylight after work or school. According to the US Department of Transportation, which has jurisdiction over DST in the US, springing forward an hour every April results in some clear benefits, despite reservations of farmers, some foreign nations, and other DST critics. For example, DST saves lives and prevents traffic injuries because more people travel home from work or school in daylight. It has been estimated that approximately 900 fewer crashes would have occurred if DST had been retained year-round from 1987 to 1991<sup>1</sup>. DST has also been shown to reduce crime because people complete their errands and are safe at home before darkness falls. Lastly, DST saves home energy consumption, which is directly correlated to the time that we go to bed. With more daylight into the later hours, we use less electricity lighting our homes, amounting to thousands of barrels of oil conserved each year.

The institutionalization of DST reflects in part the desire of individuals to use time to measure and define their successes and accomplishments and, thus, their failures and frustrations. For example, athletes often define success by whether they can run, swim, ski, or bike faster than their competitors. In everyday life, parents struggle to carve out more quality time with their families in a world where their daily work commute grows seemingly ever longer—leading to less-than-rational behavior such as speeding and, even worst, road rage. Finally, most of us will reach a point where the amount of time that we have to live on average will be less than the time that we have lived. This realization of the finiteness of individual time often promotes reflection and examination of our lifelong accomplishments and their meaning. Since most people spend more time at work than with family and friends, individuals who love their work and find it rewarding are fortunate in being able to reflect positively on their professional lives.

In medicine, time and how well we spend it are issues directly related to interactions between patients and their physicians. From the patients' perspective, time spent with their physicians is and will remain a key determinant of their satisfaction<sup>2, 3, 4, 5, 6</sup>, and invariably of health outcomes. Patients expect their physicians to spend sufficient time answering their questions and addressing their medical concerns. Thus, improved patient-physician communication is critical to optimizing an office or bedside visit, because it is not simply the quantity of time but also the quality of time that shapes patients' perceptions of their care. From the physician's perspective, the increasing amount of time spent on administrative paperwork and other non-direct patient care activities is a source of growing professional frustration and dissatisfaction with medical practice. While physicians' responses may not border on road rage, they are struggling to spend as little as possible of their professional day stuck in administrative traffic jams.

In the spirit of DST, I propose the creation of Doctor Saving Time. Through more efficient work processes and administrative streamlining, an hour per day that otherwise would have been spent on less beneficial activities can be saved for more productive professional use. The concept of Doctor Saving Time may seem straightforward enough, but achieving it will require the cooperation and expertise of payers, health insurers, government, patients, and physicians. If it can be accomplished, Doctor Saving Time, like Daylight Saving Time, can lead to fewer fatalities, less crime, and more efficient energy use. Physicians will have more time to address patients' questions about prescribed treatments and medications. More time spent on making sure that patients are clear about their prescriptions will improve health literacy and undoubtedly reduce adverse effects including death. With more time, physicians can have discussions about violence and crime prevention that are germane to the health of our patients but have until recently been less of a priority in office visit discussions. Lastly, physicians can allocate a portion of that extra hour per day to rejuvenating their bioelectricity through other activities inside and outside the medical profession. Whether it is more quality time with family and friends or time spent mentoring a medical student or new physician, a physician who is happier will undoubtedly be a better doc to his or her patients.

Given the obvious benefits of Doctor Saving Time, I am confident that even Indiana, Hawaii, and Arizona will sign on.

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Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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## ***Virtual Mentor***

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### **CASE AND COMMENTARY**

#### **Terminating a Patient-Physician Relationship**

Commentary by Kayhan Parsi, JD, PhD

#### **Case**

Ms. Evans, an OB patient at an urban public university hospital, has been abusing alcohol for some time. Dr. Davis, her obstetrician, is concerned about the health of both Ms. Evans and her 18-week-old fetus. He has repeatedly encouraged Ms. Evans to enroll in an alcohol treatment program before she does irreparable harm to her fetus. In response, Ms. Evans has enrolled and tried to follow the program's regimen, but has slipped back to a pattern of heavy drinking. Dr. Davis is getting frustrated with her inability to commit to her treatment program. Moreover, he's concerned about possible complications in the birth and the newborn's health that may arise as consequences of Ms. Evans' alcohol consumption. He feels his practice is already overburdened with high-risk patients and wants to reduce his exposure to potential liability. He decides to refer Ms. Evans to Dr. Green, a younger colleague who is not as busy.

#### **Questions for Discussion**

1. Does Dr. Davis have a professional duty to retain Ms. Evans as a patient under all circumstances? Is her non-compliance an ethically appropriate reason for Dr. Davis to attempt to refer Ms. Evans to another physician? Is his anticipation of birth complications in a practice already burdened with many high-risk patients an ethically sound reason for the transferral?
2. How should Dr. Davis go about terminating his relationship with Ms. Evans?
3. What should Dr. Davis do if Dr. Green does not wish to accept Ms. Evans as a patient?

Kayhan Parsi, JD, PhD is a fellow in the AMA Ethics Standards Group.

*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

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## ***Virtual Mentor***

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### **IN THE LITERATURE**

#### **Defining Ethical Problems in Medicine**

Keith Bauer, PhD, MSW

Bioethics refers broadly to the ethical issues and conflicts that arise in health care and the biomedical sciences. There is no uniform curriculum or set of experiences required for becoming a bioethicist. Some bioethicists receive training in philosophy and theology, while others enter the profession by way of medicine, law, or the social sciences. More recently, persons can earn advanced degrees in bioethics from newly established interdisciplinary programs. As the protean field of bioethics takes shape, those within and outside bioethics have begun to raise questions about the relationship between moral theory and moral practice. Such questions, of course, have a history that reaches back to the days of Plato and Aristotle. This debate continues today, centering not only on the relationship between moral knowledge and moral action in clinical contexts, but also on the relationship between bioethicists and non-bioethicists in the medical profession.

In "What Makes a Problem an Ethical Problem? An Empirical Perspective on the Nature of Ethical Problems in General Practice," Annette Joy Braunack-Mayer argues that the mainstream bioethics literature defines ethical dilemmas and other ethical problems in a manner that fails to capture entirely the way that general practitioners often define and think of these problems. In support of this thesis, the author presents her findings from interviews with 15 general practitioners in Australia about what they consider to be ethical problems in medical practice. She concludes that even though there is considerable overlap in how bioethics and general practitioners conceptualize and resolve ethical problems, "the moral domain is wider and richer than mainstream bioethics definitions of the nature of moral problems have allowed."

#### **Questions for Discussion**

1. Several of the "ethical issues" raised by physicians focus on concern for what patients will think or for their reputation in the community. Are these bioethical concerns?
2. Is professionalism or professional ethics the same as bioethics? Should the interests and concerns of these 2 fields overlap?
3. If physicians and bioethicists classify different sets of dilemmas and concerns under the concept of "ethical issues" is that a problem? Should bioethical concerns mirror physician concerns? Should bioethicists have clinical or health care training?

Keith Bauer, PhD, MSW is a fellow in the AMA Ethics Standards Group.

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## ***Virtual Mentor***

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### **AMA CODE SAYS**

#### **The Code as Expert Witness**

Karen Geraghty

On the last two decades, there has been a dramatic increase in the use of the AMA's *Code of Medical Ethics* in judicial rulings concerning the medical profession. Of the 225 legal citations of the *Code* since 1943, 181 have occurred between the years 1980 and 1999.

Although the *Code* itself makes no claim to legal authority, the judicial system increasingly refers to the *Code* as the standard by which professional medical conduct and practice can be evaluated and judged. In effect, the *Code* is evolving into an expert witness for professional conduct and as such is essential knowledge for practicing physicians.

When the American Medical Association was founded in 1847, the *Code of Ethics*, as it was then known, was a brief pamphlet which articulated the ideals of professional education and practice. Over the last 100 years this small volume has developed into a two-part code which distinguishes medical ethics from matters of etiquette. Incorporating the concepts of the original *Code*, the contemporary *Code of Medical Ethics* now articulates seven fundamental Principles of Medical Ethics, which "are not laws, but standards of conduct that define the essentials of honorable behavior for the physician"<sup>1</sup>. In addition, there is a statement of six fundamental Elements of the Patient-Physician Relationship, which define the rights that best contribute to the "collaborative effort between physician and patient" for the health and well-being of the patient<sup>2</sup>. Opinions of the Council on Ethical and Judicial Affairs, approved by the House of Delegates, accompany the *Code*, providing practical applications of the Principles of Medical Ethics to the dozens of ethical issues in medicine. Annotations following the Opinions highlight the judicial rulings which make use of the *Code*.

The influence of the *Code* has been significant in shaping judicial precedents in health care law. The *Code* has been cited in landmark judicial decisions such as *Cruzan*, *Bouvia*, *Tarasoff* and *Roe v. Wade* to name but a few of the more publicly known cases. For example, in *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, 303-04, a mentally competent, physically disabled woman requested cessation of forced feeding through a nasogastric tube. Quoting Opinion 2.18 (1986) [now Opinion E-2.20] the Court held that a competent adult patient has the legal right to refuse medical treatment, despite the fact that such a refusal will hasten the patient's death. In *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 p. 2d 334,

347, 131 Cal. Rptr. 14, 27, the Court, citing E-5.05, noted that it is permissible for a physician to violate the confidential nature of the patient-physician communication when disclosure is necessary to protect an individual or community from harm.

In its brief 154-year-old history, the *AMA's Code of Medical Ethics* has developed from a handbook of professional guidelines, to a comprehensive document that addresses all aspects of professional behavior in the medical setting. As the *Code* continues to evolve in the legal arena an expression of the medical profession's standard of conduct in addressing new challenges in health care such as those listed in *Bouvia* and *Tarasoff* cases, knowledge of the *Code* is, now more than ever, an urgent and necessary aspect of every physician's practice.

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## *Virtual Mentor*

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### STATE OF THE ART AND SCIENCE

#### **Taking Family Histories with Genetics in Mind**

Faith Lagay, PhD

Unless your patient has a traumatic injury or an infection, the chances are better than even that his or her complaint has some genetic component. Every day researchers implicate genetic inheritance in another physical or mental disorder—from allergy to Zellweger syndrome, heart disease to osteoporosis, cancer to learning disorders. Most disorders (or predispositions to them) that "run in the family" are not determined by single genes, and it will be a long time before disease-related genes, their degrees of penetrance, and their complex interactions with other genes and the environment are completely understood. Nevertheless, knowing what runs in the family and observing its pattern of expression can provide both patient and physician with information that helps them plan the patient's health-related behaviors, including an illness-prevention life style, frequent screening and diagnostic testing, and early management if disease is detected.

In her comprehensive *Practical Guide to the Genetic Family History*, genetic counselor Robin Bennett strongly urges capturing patients' genetic histories by drawing their family "pedigrees" (from the French *pie de grue*, or crane's foot), a term that, she explains, refers to the curved claw-like diagrams that preceded today's more rectilinear family trees<sup>1</sup>. Bennett calls the family tree a shorthand version of the family's genetic history, and certainly its diagram-and-symbol method of documenting relationships is speedier than writing out the likes of "maternal first cousin, once removed," then noting sex, age, and nature of the condition the individual displayed. Not only does drawing the graphic pedigree save time in the long term, it is probably more accurate. Asking how many aunts and uncles a patient has on both sides of the family and how many sons and daughters each one had calls these relatives into memory more clearly than broad questions such as, "Has anyone in the family had glaucoma?"

Taking the complete family history early in the patient-physician relationship avoids alarming a patient, perhaps unnecessarily, with inquiries about family incidence of heart disease, for example, or cancer, or Alzheimer's disease in response to a symptom complaint. Another advantage of the graphic is that it facilitates separating clinical patient records from genetic information, should a physician decide to protect patients from discrimination in insurance or employment by this means. While it seems nearly impossible to disentangle narrative family history, which may be offered piecemeal over many visits, from a

patient's file, comprehensive, one-page family trees on all one's patients could easily be stored alphabetically in a separate location.

The symbols and nomenclature generally used for family genetic history taking were established by the National Society of Genetic Counselors Pedigree Standardization Task Force in 1995<sup>3</sup>. They include specific representations for indicating sex, legal and biological connection, affected and carrier status, pregnancy, spontaneous abortion, termination of pregnancy, stillbirth and infertility, as well as noting connections resulting from adoption and the permutations of "blended" families. Software programs that generate pedigree charts are available<sup>2</sup> as are online sites from which pedigree programs and explanations of the symbols they use can be downloaded.

### **Taking the Family Genetic History**

Bennett offers some practical guidelines for the history-taking interview, reminding reader-history takers about the intimate nature of the information they are asking for and the psychological impact that such terms as "defect" or "bad gene" can have. She also warns against framing questions in ways that might direct the patient's answers, e.g., "Your brothers are both healthy?" With these provisos in place, the interviewer should ask about family health "from head to toe"<sup>4</sup>. Bennett asks about the (1) head, face, and neck (covering general appearance, problems with vision, speech and hearing, cleft palate, balding); (2) skeletal system (including bone formation, height, back curvature, multiple fractures); (3) skin; (4) the respiratory system; (5) cardiac system (blood pressure, heart murmurs, surgery); (6) gastrointestinal system; (7) renal system; (8) hematologic system (anemia, clotting problems, need for transfusions); (9) endocrine system (diabetes, thyroid conditions); (10) immune system; (11) reproduction (infertility, miscarriages, stillbirths); (12) neurological/neuromuscular problems (seizures and strokes, uncontrolled movements, slurred speech), and (13) mental functioning. Bennett asks about these systems at a general level of detail, progressing only to more directed questioning if there is a positive finding at the general level. At the completion of the system-by-system, head-to-toe survey, she asks separately about incidence of cancer, ethnicity, and drug and alcohol abuse.

### **Using the Family Medical History**

The "therapeutic gap" that existed between diagnostic ability and effective treatment in the 19th and early 20th centuries describes the early 21st-century schism between recognizing genetic contribution to disease and effective gene therapy to correct the problem. The best "therapy" for diseases and disorders with genetic components is prevention and early diagnosis. Prevention can be most thoroughgoing in reproductive medicine through preconception decision making, prenatal testing, embryo selection, and use of alternatives to reproduction by the rearing parents, such as adoption, gamete donation, or donation and surrogate gestation. In disorders that are influenced by both genetic and environmental factors, attention to nutrition, exercise, and other life-style behaviors, such as abstention from tobacco use and moderation in alcohol consumption, can play

preventive or mitigating roles. In mutations that confer high probability of serious late-onset illness, early diagnosis and, therefore, early management can significantly ameliorate and prolong early stages of the disease. Despite the absence of effective gene therapy at present, continuing medical education emphasizes that practitioners understand genetic contribution to illness as a way to get out in front of morbidity, diagnosing early, and helping patients plan for illness management.

The AMA has developed a series of tools for family history taking, including a Prenatal Genetic Screening Questionnaire, a Pediatric Clinical Genetics Questionnaire, and an Adult Family History Form. Getting a thorough family history does take time, and, while genetic counselors are skilled in the procedure, most patients do not see genetic counselors as part of the routine intake visit, even in primary care fields. But, given the pedigree software and online tools, medical students, physician assistants, and other office and clinic professionals who currently take patient medical histories can be enrolled to take the family genetic history.

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### ART OF MEDICINE

#### **Sketching the Role of Medical Illustrators: An Interview with JAMA's Cassio Lynn**

Sara Taub, MA

Cassio Lynn is the medical illustrator for the *Journal of the American Medical Association* in Chicago, Illinois. He is a graduate of the Medical and Biological Illustration master's program in the Department of Art as Applied to Medicine, at the Johns Hopkins University School of Medicine in Baltimore, Maryland. Cassio is currently a member of the Association of Medical Illustrators and a member of the Guild of Natural Science Illustrators.

*This figure, "Mechanism of Action of Botulinum Toxin," from the February 28, 2001 issue of JAMA, accompanies the fourth article in a series of consensus statements from the Working Group on Civilian Biodefense. The article discusses medical and public health management following the use of botulinum toxin as a bioweapon. The figure illustrates the basis of the potency of botulinum toxin. The toxin is a zinc proteinase that cleaves 1 or more of the fusion proteins by which neuronal vesicles release acetylcholine into the neuromuscular junction.*

"When you look at an image and get the message immediately, then it works," says Cassio Lynn, medical illustrator at *JAMA*, who was recently interviewed for *Virtual Mentor*. He gives the example of a billboard, noting that if you have to struggle to understand what it's trying to convey, it is not communicating with you effectively. In the world of medical publishing, readers scan the figures that accompany scientific articles as though they were "medical billboards," grasping their meaning so quickly that they seldom stop to acknowledge their presence or their origin.

Illustrations like the one featured here abound in medical publications and mainstream periodicals—they enable audiences to understand anatomical structures or physiological processes on different scales. Despite seeing these images often, we know little about the medical illustrators who create them. Lynn seems keenly aware of this, stating: "I can't speak for everyone in medical illustration, but in many ways I feel that we take a backseat role." In defining his role, he really emphasizes the notion of "behind the scene." "We are the transmitter, the tool to communicate, the middle way between, on the one hand, those who are extremely learned in a field and, on the other, their colleagues, the people in related but separate fields, and the lay public."

There is almost a paradox between medical illustrators' behind the scene work and the integral role they play in getting an author's message across. In Cassio Lym's experience at *JAMA*, once an article has been accepted, he is assigned to work on it if there is a need for illustration. "If there's a figure that needs to be done for a scientific article, we get one of several things: (1) the author's quick sketches and intended ideas for the figure; (2) whatever references the author has seen illustration-wise that almost capture what is wanted, but that don't suit the content of the message (for example, an image of the right anatomical area that is too broad or too specific); or (3) a recommendation to create an illustration for a text heavy section." From there, he draws sketches, presents them to the author, and engages in a back and forth process until they have a well-conceptualized illustration that captures the intended message and meets aesthetic expectations. The author, then, is instrumental to the medical illustration process too—"they couldn't not be, because the image has to be specific to what they want." During this time, the author also provides input on the copy-editing of the manuscript and the revision of legends that accompany figures. The efforts of the author and the editorial staff come together in the end to produce the article as it appears to the journal's readers.

Lym refers to medical illustrators as "visual editors." "Oftentimes, illustration can be more effective than a photograph or text if it can convey the message more succinctly and more cleanly." He explains how illustration, for example, can omit visual distractions that occur in reality, in an effort to focus on the more pressing subjects. "In the representation of a surgical procedure, you can eliminate the visual distraction of surrounding instrumentation or other structures within the area that don't have any relevance to the operation." It would not be possible to do this with a photograph; a textual description alone is often inadequate.

The depiction of "Mechanism of Action of Botulinum Toxin" captures how illustration allows what Lym calls the "essentialization" of target structures. Rather than depict every last detail about the cell, the illustration outlines its general shape to call to mind a smooth muscle cell. It focuses on a process that takes place in the "landmark," a specific section that has been pinpointed for the audience. Techniques such as introducing transparency to overlapping layers, or presenting the information in stages and leaving out steps that are irrelevant can enhance a message and its clarity—the ultimate goal of the illustrator, whose duty is to convey an accurate message in the most objective way possible.

"You can aim to be objective, but at some point you have to sit down and ask: (1) Who is your audience? (2) What do they really need to know? (3) How is the best way to convey that message with a sensitive hand?" Lym clarifies how the need to balance accuracy and artistic license is handled in actuality: "In most cases you have a good deal of artistic license, but that's all relative because for the illustration to work as a communication tool, you have to convey the meaning."

Medical illustrators probably have the most creative license when doing situational or editorial drawings—a drawing capturing the experience of an illness, for

example—where they provide commentary or some interpretation, rather than strictly represent factual information. These sorts of images might accompany an article on an abstract or very broad concept; they might figure on the cover of a mainstream publication running a feature story on a scientific topic. The intended effect is to appeal to people's experiences and emotions as well as to their reason. With interpretive images, illustrators try to move beyond their role of transmitting information. An effort is made to provoke a reaction in the viewer. Who will see this? How do you want to touch them? These are the questions that need to be pondered.

In addition to audience and the author's and illustrator's purposes, at least two other factors play important roles in what illustrations look like: the direction in which medicine is going and the technology available to the illustrator. About the first, Lynn states: "Illustration is changing based on what new therapies are being developed and the level at which they are administered." Molecular visualization is an area that he anticipates will receive more attention with the current emphasis on genetics. In relation to the second, he comments: "We're still defining who we are because of how much media we have at our disposal." Along with traditional media like pen and ink, paintbrush, airbrush, carbon dust, illustrators also have access to digital media. Interactive, three-dimensional, or animated illustrations are some of the multi-media alternatives that technology has made possible. "Medical illustration may not be the right term in five years—we don't really know where it's going to go as a field; that depends on where medicine goes and what media are available to us. In the future, you may be a medical animator or a medical web designer."

For now, relying on text, artistic techniques, and a variety of media, and influenced by new directions in science and close interplay with the authors of the stories they illustrate, medical illustrators are advancing our understanding by enhancing the messages we receive.

Sara Taub, MA is a research associate in the AMA Ethics Standards Group.

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## *Virtual Mentor*

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### PERSONAL NARRATIVE

#### **"Hey Doc! Something's Crawling Out of My Foot."**

Robert Davidson, MD, MPH

My patient population in Eastern Africa is the Peace Corps volunteers in the five countries I serve. They are a truly remarkable group of individuals. I have great admiration for their fortitude and sense of adventure. Most of them do very well from a health standpoint and return home healthier than they came. In my training activities with new volunteers, I often use the analogy that their two years of overseas service is like a life stress test. I explain the use of stress testing for diagnosis of conditions such as coronary artery disease. I go on to say that if they have medical problems, these will probably get worse during the two years. However, if the volunteers learn to cope with these problems, they will be much stronger and able to adapt to future life stresses when they turn to whatever they do next.

Most of the health problems we see in volunteers are relatively minor and predictable given the environment they live in. Infectious diseases are by far the most common. My son the medical student reminded his mother several times during his microbiology-parasitology course that each lecture usually included the statement that this particular disease is predominately found in sub-Saharan Africa. Even though we spend a lot of training time on water and food purification and preparation, diarrheal diseases are a common and almost expected part of Peace Corps life. The volunteers become quite adept at describing stool quality and frequency. The laboratory gets lots of business from us requesting tests for ova and parasites in stool specimens. While most diarrheal diseases are self-limited and presumed to be viral, we do see *Giardia lamblia*, *Entamoeba histolytica*, and a variety of bacterial stool infections. One illness that everyone worries about but we rarely see, or at least rarely diagnose, is cholera. We do not vaccinate against cholera, as the efficacy of the vaccine is not very high. The news media and many concerned parents see cholera as a major threat. There are periodic cries for mandatory cholera vaccination prior to entry in country. Luckily, cooler heads in the Ministry of Health prevail.

Malaria, endemic in many parts of the East Africa countries, kills more people than anything else, more, even, than the HIV/AIDS scourge. *Plasmodium falciparum* is the species we worry about most because of its potential for cerebral penetration or destruction of blood cells [Blackwater Fever], both of which are potentially fatal complications. All Peace Corps volunteers are required to use anti-malaria prophylaxis, although some try to get by without it because they do not like the side

effects of some of the medicines. Diagnosing malaria is a major problem. Laboratories in the smaller rural areas and community clinics seem to report positive malaria smears automatically on any sample we submit. When we have the samples re-examined at the excellent laboratories associated with the major hospitals in Nairobi, often no evidence of parasites is found. Since many of the volunteers are located so remotely that it may take them two to three days to get to an urban area, we supply them with sulfadoxine / pyrimethamine [Fansidar] for interim self-treatment. We teach them to make a thick and thin blood smear at their site, take the Fansidar, and start the trek to their designated urban area. This seems to work well. If the slide is truly positive, then we give a full course of either oral or IV drugs. We do see a few cases of proven malaria in volunteers, but so far they have been easily treated. Several years ago, however, a volunteer in Kenya died from malaria. We maintain a high respect for the disease, work to prevent it, and treat it aggressively when we find it.

Schistosomiasis is endemic in several of the areas I cover. Lake Malawi and Lake Victoria are known reservoirs for both *S. haematobium* and *S. mansoni*. It is impossible to keep sweating, itchy volunteers from jumping into or wading in the cool inviting waters of these beautiful lakes. We are almost never able to identify the eggs in either urine or stool. In the absence of symptoms, we postpone drawing blood for schistosome serology until the volunteer has left the endemic area. If the serology is positive, we presume infestation and treat it. Often, the serology results are not available until the volunteer has returned to the US. They are contacted by the Peace Corps and told to go to a local physician for treatment. I got a panic call from a family doctor in a rural town in Colorado who had an anxious volunteer in his office with a positive serology to *S. haematobium*. They forgot or ignored the time difference, so here I was at 3:00 a.m. trying to wake up and remember the treatment for schistosomiasis. I guess they don't see a lot of this parasite in rural Colorado.

For sheer numbers, the most common class of health problem in the region is skin disorders. Cellulitis is much more common here than in the States. I don't know whether it's the virulence of the bacteria, the difficulty of hygiene without running water in your house, or both. Minor bites or scrapes frequently evolve into cellulitis, requiring drainage and antibiotics. The fungi seem to love our volunteers also. Tinea *something* seems to show up in almost every volunteer at one time. The common blister beetle known locally as "Nairobi Fly" causes a frequent, though very unsettling, problem. In the usual scenario, a volunteer slaps a bug on his neck with a subsequent large area of second degree burn from the caustic substance secreted by the beetle. We treat the condition symptomatically, but even topical steroids do not seem to offer much relief.

One skin problem that brings revulsion to the hardest volunteer is the work of the tumbu fly, *Cordylobia anthropophaga*. This enterprising bug deposits her eggs under the human skin. There they develop into larvae, which crawl out through a breathing hole when mature. "Hey Doc.! Something is crawling out of my foot." I

was with a young woman volunteer in Tanzania who was, with my guidance, extracting some larvae from her leg when her parents called from the States. Just as she began to describe to her anxious mother what she was doing, the phone line went dead. I had visions of these two parents sitting up in bed in the middle of the night, wide awake now with fear for their daughter, wondering what the hell was going on. I imagined a call from a congressman to inquire about what we were exposing these young Americans to. Luckily, the parents were able to call back and I allayed their fears. The volunteer found some preservative to keep the larvae in and planned to take them back with her to the States to put in a prominent place on her mantle. I am sure it will be quite a conversation piece; the story surrounding it will grow increasingly outlandish over the years. I also hope she gets a good story ready for the immigration officers who want to know what's in the bottle.

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## ***Virtual Mentor***

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### **PERSONAL NARRATIVE**

#### **Moral Wounds: Complicated Complications**

Faith Lagay, PhD

As a complication of her partial thyroidectomy, Shari Munch, PhD, has permanent paralysis of one vocal cord, a possible outcome about which her surgeon did not inform her. In this *JAMA* article, Dr. Munch discusses the psychological harm and damage to trust caused by the surgeon's failure to tell her about the risk of vocal cord paralysis before the operation. She invited her surgeon, Dr. Lewis deKryger, to respond to her essay, and he did so. In his portion of the dialogue, Dr. deKryger explains that he decides what to tell patients preoperatively based on his assumptions about what they already know, e.g., the risk entailed in any surgery, and on his previous experience in performing the particular surgery they will undergo. He admits to not reflecting at length on the possible "moral wounds" of incomplete disclosure.

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## *Virtual Mentor*

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### **PERSONAL NARRATIVE**

#### **"But I Don't Eat Sweets": The Puzzle of Patient Noncompliance**

Michael Bevins

Nowadays, a large part of primary care medicine involves the treatment of chronic diseases like hypertension, diabetes, and high cholesterol. Such conditions can be very difficult to manage, especially when they cause their bearers no sensible burden. A seemingly simple plan, some slight diet modification, and a couple of pills a day, for example, can prove nearly impossible to carry through, hence the ubiquity of what is somewhat condescendingly referred to as patient non-compliance. Unfortunately, we have yet to find a way to make ourselves do what we know we should, let alone the key to making others do what we believe they should. Nevertheless, the blame for medical sins of omission, such as failing to take medication or to quit smoking, is most easily placed on the patient.

Anyone who spends time in a Family Medicine clinic will become acquainted with this problem, even a second-year medical student like me. One day, I met Mrs. Gracia, a friendly Hispanic woman in her mid-fifties with a history of diabetes and hypertension, for both of which she took medication. According to her records, the hypertension was well controlled. The diabetes was another story, however. For as far back as her records went, about two years, the blood tests used to monitor her diabetes had been significantly elevated. Not surprisingly, on that day her blood glucose was more than double what it should have been. After looking at the records, I recalled some of the complications of diabetes: neuropathy, heart disease, vision problems, kidney damage, and I rehearsed some pertinent interview questions before introducing myself and asking Mrs. Gracia how I could help her.

Well, she just needed to refill this medicine here and other than that everything was good. She told me she felt great, was active, had been taking her medicine, and had no problems. But health is so unsatisfying for an eager medical student; perhaps I'd just have to get specific. Fatigue? No. Weight changes? No. Chest pain? No. Numbness or tingling in her hands or feet? No. Vision problems? No. Urinary problems? No. Infections? No. Appetite changes? No. We continued like this until I had exhausted every avenue I could think of by which to uncover a sign of ill health. But she would not budge. In fact, if not for her persistently sky-high lab values, you'd never know Mrs. Gracia had diabetes.

Measuring your blood pressure at home? No. How about your blood sugars? No. She didn't like needles. "But I really don't eat sugar," she added, "You know, that's why I don't get why I have sugar diabetes: I've never been one to eat sweets." At

this point, I explained to Mrs. Gracia that she could have too much sugar in her blood even if she didn't eat a lot of sweets, and that people didn't get diabetes from eating too much sugar. She seemed surprised to learn this, but she said she understood. Nevertheless, I remained unsatisfied, and I sensed that the issue had not been settled for Mrs. Gracia either. Surely, I thought, this had all been explained before, probably many times. But then why didn't she get it? And why did I get the feeling that she didn't believe what I had just told her?

Demonstrating the generosity of most patients who participate in medical education, Mrs. Gracia did not object to being seen twice more: once by the resident and myself, and once with the addition of the attending physician. But when questioned the second and third time, both in Spanish, her story remained the same: no problems. She again admitted to not measuring her blood sugar at home, although she claimed to be taking her medications. The physicians were concerned about her lab values, however, and they tried to stress the importance of home monitoring. Mrs. Gracia nodded along and said, "Ok," when told she would have to stick her finger every day to measure her blood sugar. Was she acquiescing, or just being polite?

During the third interview, she repeated her puzzlement at the diagnosis of sugar diabetes, since she didn't eat much sugar. Again it was explained, this time by the attending physician, that her diabetes was not caused by eating lots of sweets. Surely she understood now. Surely everything would fall into place now that she had been offered this fact with the endorsement of two-and-a-half white coats. But she seemed as surprised to hear it as she had been when I told her the same thing not twenty minutes before. Had I not been clear? Or did she just need to hear it from a doctor? Either way, she said she understood.

Perhaps because of my mediocre Spanish skills, my wandering mind, or something else, I'm not exactly sure what happened next, but Mrs. Gracia became angry. It seems the attending physician implied that Mrs. Gracia had been remiss in her treatment. Perhaps she hadn't been taking her diabetes medication or sticking to her diet, because her lab values should not be so high if she were doing as she was supposed to. Her response was surprising: This previously soft-spoken, pleasant woman shouted, "Believe me or don't. But I do not eat sweets!"

I understood this much: That she could have high blood sugar, despite not eating a lot of sweets, had not reached Mrs. Gracia. But how could that be? She said she understood. Maybe she hadn't after all, or maybe she just didn't believe it. Either way, I could practically see that simple fact gasping for life at Mrs. Gracia's feet, lying on the floor between her and the attending physician. For some reason, it simply could not find a place among her worries over meals, work, husband, laundry, prayers, bills, etc.

The attending physician reassured Mrs. Gracia that he believed her, but that he was very concerned about her high blood sugar. It was no use. There was no getting

beyond the wall that had gone up between the patient and the doctor. Despite the unusually large amount of time spent with her, Mrs. Gracia was not convinced, and now she was angry. She was going to continue with her daily activities as she had before: not eating sweets, not sticking her finger, maybe taking her medication, still not understanding why she had sugar diabetes. Nevertheless, a respectable effort had been made, and the effort would be made again. Meanwhile, other patients were waiting.

Granted, many people manage their chronic conditions very well. But the ones that don't should concern us. As a student, I have been assigned to physicians who seem not to have even one non-compliant patient, while others have more than their fair share. Nevertheless, the key to success remains elusive. Perhaps it lies in a place we are unlikely to look. Most of us are inclined to locate the blame with the burden, that is with the patient, who after all must take the medicine, eat the vegetables, do the exercise, etc. But this is too facile, just as is blaming the physician. In those difficult situations in which it works, managing chronic conditions seems to depend on what exists between the patient and her doctor, on a relationship of mutual understanding and reciprocal responsibility. Far from being a set of instructions that the patient must follow, successfully managing diabetes, hypertension, and the like is a process in which both patient and physician are mutually engaged and from which both benefit. In short, the responsibility for managing chronic disease is a shared responsibility. Unfortunately, these are often the hardest responsibilities to fulfill.

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## *Virtual Mentor*

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### **VIEWPOINT**

#### **Healing at the End of Life**

Bruce Bartlow, MD

The way your patient is dying is taking everyone down with her. Doctors, nurses, friends, and family are all at each other's throats about whether to keep her alive. "How can you make her suffer any more?" "Why do you want her to die?"

She'd even filled out an Advance Directive to avoid just such a horror show. Somehow, they never make things clear. She checked the box that said, "Do not keep me alive if . . . I'm terminal, in permanent coma, if it will only delay death, or if the burden outweighs the benefit." But we're all terminal. How imminently terminal was she talking about? Medical care can only delay death. And burden, benefit—who knows what she would consider too much burden to achieve a given outcome?

At the end of a day of doing your very best, you go home feeling wounded and powerless. Wouldn't it have been better if you'd learned to drive a truck?

Our first thoughts of mortality usually begin with an illness. It's likely death will find us in a hospital. With few exceptions, it will feel like a defeat of everything we'd hoped to achieve. We hear about "good deaths" with Hospice, or on programs like Bill Moyer's PBS series, "On Our Own Terms." What goes wrong in hospitals that we so seldom experience this fabled "good death"?

Years of clinical work and ethics consultation have convinced me that we make such a mess of the end of life because we focus on *procedures* rather than on *goals* and *needs*. We prolong life, but ignore life's purpose. Family and friends may spend three months at their loved one's bedside while we scurry around, do things, explain situations, make decisions. We ask for consents; we write orders. At the last moment we ask, "Should we go on?" or "What do you want us to do?" Then we write a "DNR" and hurry from the room to get busy with more salvageable patients.

What would happen if we changed our viewpoint, asked an entirely different set of questions? Could it be that the approach of death offers all of us—the dying patient, family and friends, healthcare providers—a uniquely powerful opportunity for healing? Why did each of us come to participate in the end of this individual's life? What do we hope to face, or learn, or let go of? The appropriate procedures are those that will help us achieve those goals.



Beyond that, how would we turn such questions into action? The usual answer is, "I don't have time." For a hundred procedures and endless regrets, I have time. Can't I find five minutes to explore what we're here to win with all our effort?

### **Soul Work**

(1) A simple first step is to change our Advance Directives so the patient can express her values, her fears, and her hopes. One I use emphasizes quality of life, burden of therapy, and life goals, rather than procedures.

We can start with, "What do you need to complete before you die? Does this illness bring up some thoughts of what you came to this life to do? What outcome are you most afraid of? What would you like to see happen?" This entire discussion can take only a few minutes, or can be a rich part of your relationship to your patient over months or years.

(2) Recognize that the patient is not the only one preparing for the end of her life. The family and friends are facing a loss, as well. What do they need to settle with this person? How can they be enriched rather than devastated by how the last of this life is lived? How will our treatments shape the stories they remember from this very special person's life? Explore the values and power of the last of life, so dying patients and those who care for them can utilize this time well. Ask what the patient and family need to achieve. Will our interventions facilitate this, or block it?

How would they like the final scene to go—the place, the music, the crowd, the smells? Then let us help make that happen.

(3) "Medicine" treats the body as if it has no connection to what will survive beyond the death. If we perform CPR or other procedures, not believing they will benefit the person, will the individual's spirit thank us or hate us for how we treated her? What will our actions tell her about the world and her place in it?

(4) I've come to believe that health care providers avoid dealing with death not because we "don't have the time," but because we're barricaded against our own fears, hopes, and humanity. This isolation harms us as well as our patients and their loved ones. Walk through that barrier. Why did you choose to immerse your life in sickness and death? What wound in yourself is calling out to be healed by your experiences? You got what you came for; now don't turn from it.

Our professions offer us access to one of mankind's richest, most powerful transitions. Our patients and their families wait to offer us their hearts, their life dramas, their wisdom. Like a grandfather who turns to his newborn grandson and asks, "Tell me about the other side. What's it like where I'm going?" our patients offer a mirror in which we can discern our own needs and our own futures. When we dare to receive their gifts, we all go home refreshed and grateful at the end of the day.

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### **VIEWPOINT**

#### **Balls, Strikes, and VIPs**

Audiey Kao, MD, PhD

- July 4, 1939 was Lou Gehrig Day at Yankee Stadium. By then, the public knew that Gehrig, nicknamed the Iron Horse because he had played in 2,130 consecutive games, was stricken with amyotrophic lateral sclerosis, a progressive neuromuscular disease that is usually fatal within five years of diagnosis. Despite his illness, Gehrig still considered himself "the luckiest man on the face of the earth." Inducted into baseball's Hall of Fame in 1939 after the five-year waiting list was waived due to his illness, Lou Gehrig died on June 2, 1941 in Riverdale, NY.
- Doug Dravecky, a left-handed pitcher for the San Francisco Giants was diagnosed with an osteosarcoma of his left humerus in 1998. Amazingly, Dravecky returned to pitching in the major leagues after undergoing cancer treatment. After recording 2 more wins in his comeback, Dravecky suffered a pathological fracture of his treated left humerus while pitching and ultimately had his left arm amputated in order to treat the cancer.
- As a high school sophomore, Mickey Mantle nearly had his left leg amputated as a result of osteomyelitis, but luckily a new drug called penicillin saved his leg and thus his future baseball career. To many of his admirers, his career was capped in the summer of 1961 when he and Yankee teammate Roger Maris were both chasing Babe Ruth's record of 60 home runs in a single season. Maris ended up breaking the record with 61, while Mantle had 54 homers. Throughout his career, Mantle often played in significant pain due to a chronic muscle ailment.
- After Mantle received a liver transplant in 1995, some claimed that celebrity status played a determining role in his getting a donor organ in a relatively short period of time. In response, the United Network for Organ Sharing conducted an independent review of the circumstances surrounding Mantle's liver transplant. They concluded that, in this highly publicized case, the organ had been allocated properly and according to established policy.
- Concerns about special care of "VIP" patients including famous athletes remain. From the quality-of-care perspective, some criticize the fact that VIP patients get preferential treatment that the average patient might not receive. In many academic health centers where VIP patients come for the latest medical treatments and cures, there are some who feel that the VIP patients should have the same obligation as other patients to participate in the training of medical students and residents<sup>1,2,3</sup>. If this is true, then VIP patients should receive the same respect for privacy and confidentiality

accorded other patients. Apparently this is not always the case, as when non-treating health care personnel access the medical records of VIPs without authorization or apparent need.

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### VIEWPOINT

#### **The Trend Toward Casual Address and Dress in the Medical Profession**

Sara Taub, MA and Kayhan Parsi, JD, PhD

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

Which of the following responses (A,B,C,D) shows the best understanding of medical etiquette, as you begin the important task of building a good "doctor-patient relationship"?

A. Hoping to win your new physician's approval, you nod politely, shake the hand of this impressive authority figure . . . and then murmur respectfully: "*It's a privilege to meet you, sir.*"

B. Doing your best to prove that you can be just as chummy and informal as the doctor, you slap his shoulder, while barking enthusiastically: "*Great to meet ya, Doc! When are you free for a round of golf?*"

C. Enraged by the doctor's breezy, patronizing use of your first name—while he insists on referring to himself as "*Dr. Hotchkiss*"—you snap furiously: "*Stop calling me Bob! And if you touch my shoulder again, I'll have you arrested for battery!*"

D. Speaking politely but firmly, you tell the doctor: "*Before we start talking about medical issues, we need to discuss our relationship . . . including the way that we're going to address each other. I need to feel that there's trust and respect on both sides*"<sup>1</sup>.

The "dotcom" revolution of the 1990s brought with it many changes. One of the more enduring is the movement toward casual dress in the workplace. Suits and ties are out. Polo shirts and khakis are in. Ninety percent of US companies allow some form of casual dress, up from 62 percent in 1992<sup>2</sup>. Traditionally staid employers such as law firms and banks are enthusiastically jumping on the casual bandwagon, though some still require formal attire for interactions with clients. Employers argue that it is a perk that improves worker morale, yet costs nothing.

This "casualization" in the workforce is but one component in a larger cultural trend in which social relations and forms of address are less formal than they were a couple of generations ago. Adult peers typically dispense with formal titles of

address (Mr. or Ms.) and usually move directly to a more familiar first-name basis. This may reflect a certain democratization. It also may reflect the influence of youth culture, where informality and spontaneity are greatly prized. Is society better off with more formal or informal styles of dress and address? Is this an ethical issue or one of mere etiquette? Does what we think of as "mere etiquette" have some ethical significance? Going back to the opening scenario, does physician etiquette affect the therapeutic relationship?

Casualization has indeed influenced dress and behavior within the health care arena. Nurses long ago shed the white uniform and cap for more practical and comfortable garb. Certain television shows, such as ER, have helped popularize the surgical scrub as the uniform de rigueur in medicine. Some places, however, attempt to draw the line in casualization. Take, for example, the following admonition against the ubiquitous scrub in an orientation guide of new residents at an academic medical center:

"The . . . clinics operate in a casual atmosphere that seems to make the patients feel more comfortable and responsive. Many of the employees, nursing personnel and physicians dress in a casual manner. Although a tie for men and similar level of formality for women is preferred, more casual clothing is acceptable so long as it is clean and in good repair. Scrub suits are not acceptable."

Another academic medical center reinforces the notion that casual dress may not be in the best interest of the patient-physician relationship:

"A physician's appearance serves as a powerful, nonverbal symbol that affects communication between doctor and patient. Patients react negatively to jeans, athletic shoes and socks, scrub suits, clogs, prominent ruffles, dangling earrings, and excessive aftershave lotion or perfume. Patients express preference for well-trimmed hairstyles"<sup>3</sup>.

Physicians have mixed responses to these matters, as exemplified in an exchange of letters in the *Newsletter* for the American Society of Anesthesiologists<sup>4</sup>. One physician claimed that "[y]ou have to 'talk the talk', 'walk the walk' and 'dress the dress' if you want to be recognized as a physician." Another stated that "[w]hen it comes to our attire, anesthesiologists need to stop being so egocentric: we dress for our patients and for the professionals with whom we work, not for ourselves." And a third added "[h]ow many times has the perception that we are slob affected interactions with the public, other physicians, hospital administrators and health care organizations?" But a dissenting voice felt that "[n]o amount of gaudy, expensive dress will ever make some anesthesiologists professional . . . a physician can act professionally regardless of what he or she is wearing."

The range of perspectives represented in these comments points to the larger question: Does casualization compromise the therapeutic relationship? There are those who argue that physicians' professional wear and behavior play an

instrumental role in their communication with patients, inspiring confidence and credulity and indicating respect and a desire to please. If this is indeed the case, casualization may indicate a significant change in how physicians choose to relate to their patients—one that could have consequences for patient care and deserves to be looked into further. On the other side of the debate are individuals who claim appearance and attitude are mere matters of social etiquette. A physician's medical abilities are what really matters; questions of dress and address are frivolous criteria by which to judge a professional responsible for promoting medical well-being.

Whether casualization in the doctor-patient interaction is one-sided or reciprocal may color general reactions to the trend. If the relaxing of social etiquette norms is exercised only by physicians, it could reinforce the power differential that already exists between patient and physician, rather than foster a more comfortable environment for all. The white coat worn by physicians has long been criticized as a symbol of power that skews the medical encounter. Now its shedding seems like it could engender the same types of complaint, if it isn't accompanied by a corresponding trend toward patient's leaving formality behind. If patients continue to dress up and use titles and last names when they address medical personnel, while physicians dress down and adopt first name designation, casualization could steer us in a direction we have tried to avoid—toward an almost patronizing system where one party is paid more respect.

So Dr. Hotchkiss (no matter what you're wearing), before you slap Bob on his back, give some thought to whether you want him to call you "Joe."

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### **VIEWPOINT**

#### **Bac Si My: An American Doctor in Vietnam**

Karen Geraghty

In the summer of 1965, at the request of the South Vietnamese authorities, a small group of American physicians arrived in Vietnam as part of a humanitarian effort to care for civilians in Southeast Asia. Twenty-five years of war and insurrection had created tremendous health burdens on the population, and, as increasing numbers of Vietnamese physicians were pressed into military service, fewer than 350 native physicians were left to care for more than 5 million Vietnamese civilians. This first small band of American physicians who arrived in 1965 represented the beginning of the Volunteers for Vietnam Program, a humanitarian initiative that, by 1967, was administered by the American Medical Association and funded by the United States Agency for International Development. Physicians volunteered for a 2-month tour of service in Vietnam during which they were paid \$10 a day. From 1967-1973, a total of 774 American physicians served 1,029 tours of service in Vietnam.

One young physician who answered the call to humanitarian service was William W. Funderburk. Leaving behind his wife, their 3 small children, and his surgical practice at Freedman's Hospital in Washington, DC, 36-year-old Dr. Funderburk embarked on a 2-month tour of service in October 1967. Dr. Funderburk had been exempt from military service during his medical training, and the volunteer program provided him with the opportunity to use his surgical skills where they were desperately needed.

He was assigned to Danang, a city of about 250,000 people on the coast of the South China Sea. The Danang Surgical Hospital treated 15 percent of the war casualties in South Vietnam and nearly 50 percent of all casualties in region 1 of the count. (Vietnam was divided into 4 regions with region 1 the second largest.) Overcrowding was severe—the surgical unit, designed for 350 beds, housed 500-600 patients, while the medical unit, designed for 200, accommodated more than 300 patients.

His days were long and challenging - over 65 percent of Dr. Funderburk's surgery was on patients with war-related injuries. He stated that "the multiple war casualties which were seen and treated were far out of proportion to anything that might be envisioned in the US, and the types of wounds were unique"<sup>1</sup>. He also treated diseases prevalent in the region such as plague, typhoid, malaria, cholera, and hookworm disease.





Hospital beds did not have side railings. Due to this hazard and the severe overcrowding of the wards, patients were often evaluated and treated on stretchers placed on the floor. Image courtesy of the *AMA Archives*.

In addition to caring for patients, Dr. Funderburk served as an advisor to several interns who rotated through the hospital at Danang from the medical schools in Saigon and Hue. The students spent 2 months at the hospital in surgical training under the direct supervision of Dr. Funderburk and two senior Vietnamese physicians.

Dr. Funderburk continued his mentoring role when he returned to the US, sponsoring 3 young Vietnamese interns to visit the United States for further medical training.

Upon his return from life as a Bac Si My (American doctor) in Vietnam just before Christmas of 1967, Dr. Funderburk commented that although he witnessed much suffering in Danang, he "wouldn't change those 2 months for any 2 months I've spent in medicine and surgery"<sup>2</sup>.



Dr. Funderburk with pediatric patients in Danang Community Hospital. Image courtesy of the *AMA Archives*.

For his commitment to the professional ideal of patient care wherever the need and regardless of the language, political, and cultural barriers, his willingness to subject himself to danger and inconvenience to bring comfort to the sick and wounded, and his role as mentor and advisor to young students, we are proud to name Dr. William W. Funderburk a role model in medicine.

### References

1. Funderburk WW. End of service report, *American Medical Association, Volunteer Physicians for Vietnam*. Dec. 1967 (unpublished). Courtesy of AMA Archives.

2. Funderburk WW. End of service report, American Medical Association, Volunteer Physicians for Vietnam. Dec.1967 (unpublished). Courtesy of AMA Archives.

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