

Professionalism: Capacity, Empathy, Humility and Overall Attitude

Robert A. Raschke, MD

Banner Good Samaritan Medical Center

Phoenix, AZ

Recall we have previously defined professionalism and agreed on our primary goal as physicians, and reviewed competing goals that sometimes threaten to distract us. Recall that the Oath of Maimonides brought to mind a few attributes of the good physician that we discuss next. This list is not complete, but a good start. (If you think of others, please comment – I am trying to learn this topic myself in more depth, and would appreciate your thoughts).

Capacity

You have to be cognitively, psychologically and physically healthy to do your best work, but we all have natural tendencies that might need to be overcome in order to optimize our capacity. For instance, I am fundamentally very lazy intellectually (and otherwise). I found I had trouble keeping current with medical literature once I finished fellowship training and went into practice, since I no longer had to worry about being periodically formally tested. But my career choice in medical education helped counteract my laziness. I started a monthly Critical Care journal club within our fellowship, which conveniently fulfills my job duties, but has the personal benefit of forcing me to keep up to date, practice formal rules of critical appraisal, and come to firm conclusions about whether and how each article should impact my patient care. I strongly recommend considering a career in a teaching program as an aspect of your personal professionalism. I'm not implying that doctors in non-teaching positions *can't* be highly professional – this clearly isn't true. But a teaching job emphasizes maintenance of your cognitive capacity and other aspects of professionalism as specific job duties, and protects time for you to work on them.

Teaching also multiplies our ability to bring wellbeing to our patients, through the professional actions of those who have learned from us. I seldom thought about this until just recently – but now it strikes me that we might do more good through the hands of our pupils than through our own.

I have had an interest in hemophagocytic lymphohistiocytosis for about 15 years, and have been made fun-of over the years by some of my partners because of my Don Quixote-like pursuit of that esoteric diagnosis. Persistence paid off though, and I was partially vindicated when I was able to publish a paper describing our experience with HLH in the adult ICU. I also presented our findings in relation to HLH many times to our residents in morning report and Grand rounds.

About a year ago, I received a phone call from one of our graduate residents, who had gone on to open practice in Flagstaff AZ – about a 2-hour car ride north of Phoenix. He was cross-covering a hospital service, and had picked up the care of a hospitalized 21-year old girl with fever of unknown origin, that reminded him of a patient with HLH that I had previously presented in morning report. He correctly diagnosed her with HLH, and was calling to arrange transfer down to Phoenix so that we could take her treatment forward. None of his partners had ever heard of HLH before and therefore had no chance of diagnosing it, and the patient having developed shock and multisystem organ failure would almost certainly have died without specific therapy. After a prolonged ICU stay she survived. Eventually she rehabilitated and returned to finish her college education at Northern Arizona University. My academic interest in HLH, and my role in teaching residents about it, had amplified my professional capacity in a way that I hadn't expected.

Happiness in your personal life will reflect on your professional capacity. This can be a very difficult balance, but your job as a physician should not endanger your primary personal relationships. If it does, you might want to look for a different practice, or different specialty within medicine. Enlist your spouse or partner in your work struggles. My wife (of 30 years) Carolyn has been a wonderful blessing to me in this regard. Carolyn is a teacher, but she knows a lot of

medicine. She learned it by listening to me vent my work-related frustrations over the past many years. I sometimes bounce cases off her just to ask her what she thinks, having found that her intelligence and keen deductive powers often lead her to the proper course of action, even if she doesn't know right medical semantics. At times, I feel like I can withstand almost anything that happens in the ICU because I know that Carolyn will be waiting to give me a hug when I get home. Do not sacrifice this blessing for your job, instead make it part of why you are a good doctor.

Physical health will also reflect on your professional capacity. Exercise regularly. Your routine workload ought not to prevent you from working out. If it does, I would recommend you figure out a way to remedy that, because you and your patients will ultimately suffer if your work hours are unhealthy for you. But I think this is rarely the case if you nurture good personal exercise habits. Figure out the physical activities that you enjoy, and make time for them. You ought to be able to get *some* exercise even during your busiest work weeks. Even a 15-minute work out is better than none at all, especially if you make it habitual over the long course of your life. Whether you enjoy walking your dog, running, yoga, weight-lifting or kayaking, your capacity to do good work will benefit from regular physical activity outside the hospital.

One last thought about capacity: Don't take a job that would exceed *anybody's* capacity to provide good care. I have seen hospitalists with a work list of 40-50 patients for their weekend rounds. No matter how efficient you are, no one can reliably do a good job with that magnitude of workload. As professionals we should set limits on how far we let business people direct our practice of medicine.

Empathy

I once overheard an intern handing off the care of a patient to another intern, mention that he had ordered the nurse to "throw a Foley in" the patient. I may have been unfair in my quick judgment of the intern's apparent lack of empathy, but the way he made this statement struck me as nonchalant, with an attitude that the insertion of a Foley catheter was of little consequence one way or

another. I had not experienced having a Foley myself at that tender point in my life, but it did strike me that I wouldn't want one unless absolutely necessary (in fact, it gave me the heeby-geebies just thinking about it). I have wondered if we should all have to have IVs and Foley's put in us during medical school, just to help us understand that procedures that seem trivial to doctors can be very stressful to a patient, and should not be undertaken without careful deliberation. Many physicians relate experiences of personal illnesses to the growth of their own empathy towards their patients. I've noticed that as I get older, more and more of my patients are about the same age as my children. It helps me to see my son or daughter in these young patient's eyes, and helps me appreciate how scared they might be. But we can't wait to have children, or to get sick in order to develop empathy. The best I have been able to do is to actively seek empathy at the bedside of my patients. The more you know about your patient, the more likely you are to feel it. If you don't particularly feel it, you can at least practice the actions of empathy. It's difficult to imagine a physician without empathy attending properly to all aspects of the pain and suffering of their patients. Depending where you work, the proportion of patients who end up in the unit because of self-destructive behavior can sometimes get overwhelming. There are times when I have estimated that fully two-thirds of the patients on my service were there because of alcohol and drug abuse. It can be challenging to empathize with patients who are morbidly obese, or who are narcotic-seeking. We have recently seen epidemic proportions of both in our unit. Recently, I was asked to consult on a 45-year-old woman with cellulitis. She had ceased walking 18 months ago because of progressive morbid obesity. She had severe emphysema related to a long history of smoking, and severe obstructive sleep apnea, but refused to use oxygen and BiPAP breathing-assist device that were prescribed by her physician. She had several doubtful unconfirmed diagnoses such as fibromyalgia for which she was addicted to narcotics. The reason I was consulted is that she was having progressive difficulty breathing. But the cause of this seemed pretty obvious to me – she had smoked 3 packs a day for 25 years,

and she weighed almost 450 lbs. She was so fat it was amazing she could breathe at all.

She was at rest as I entered her room, but when she awoke to my presence, she suddenly appeared in painful distress. It looked to me like she was faking it. I couldn't get her to give me any useful history. All she wanted to talk about was how much pain she was in - *when was her next dose of narcotics due?* On examination, she was extremely poorly-kept, smelled bad, and had an abdominal pannus that literally hung down to her knees even while she was laying flat on her back. The chaffed skin underneath was where her cellulitis had blossomed. I have to say in all truthfulness that I was *disgusted* by her physical appearance, and I judged that her illness was 100% self-inflicted.

I think she might have sensed my unkind thoughts, because I could tell she didn't like me much. She became very upset with my decision to withhold additional narcotics because they might *worsen* her breathing. I was relieved when I left her room, but we were clearly adversaries.

Before I came back to see her the next day, I thought about Maimonides prayer – “May I never see in the patient anything but a fellow creature in pain”. How could I bring myself to *sincerely* look at this lady as a fellow human being in pain when I had such a judgmental attitude about her? I pondered this as I entered her room to look in on her. I noted that she had required intubation overnight as I expected she might, but she was not heavily sedated, - in fact, she was actually *more* alert than she had been on the previous day. Although awake, she couldn't speak because of the endotracheal tube – this was probably helpful, because it prevented her from riling me by asking for more narcotics. No one else was in the room.

I didn't have a good plan for how to proceed, but I knew I wanted to make an effort to nurture some empathy for her. Without thinking too much about what I was doing, I took her hand and told her that I knew that everything that had been happening to her over the past few years had been very tough for her, and that I knew she was suffering. I said that she had a tough road ahead as well, but that

we had some ideas that could help her (tracheostomy), and that I was going to do my best to get her better so that she could return home as soon as possible. I could feel these words become sincere as I said them. At one point I referred to her as “sister” – not as slang term - but as a way to express to her that I cared about her as a person. This wasn’t a technique – it came out of my mouth in response to kind feelings that I was beginning to have towards her. She listened attentively, and her eyes even got teary. When I was done, she wouldn’t let go of my hand for awhile. I didn’t know what else to say, so I just stood there holding her hand until it seemed like it would be OK to let go.

Another patient who taught me about empathy was a Native American woman who was admitted for an infected stage IV sacral decubitus ulcer. She was in her early-sixties, but she was a wreck. She had a history of noncompliance and had suffered severe sequelae of diabetes, with advanced ischemic heart disease, dialysis-requiring renal failure, blindness, and bilateral above-knee amputations. I remember that when I first heard about her, a very unkind thought entered my mind. Before I ever even met her, I questioned whether it was worth to exert the effort to get her over her acute illness. Her body was so ravaged that I felt that her life wasn’t worth the extensive effort it was going to take to prolong it.

I realized this was a very bad way to think of a patient, so when I met her, I asked her some questions unrelated to her medical history, for the sole purpose of learning more about her – in a search for empathy – in an attempt to understand the value of her life. I asked about her kids, and she told me a story about her youngest son that stuck in my mind. She said she was driving with her husband down a lonely unpaved road on the Indian reservation one day, about ten years previously, when they saw a boy about 12 years old walking off on the dusty shoulder ahead of them – miles from the closest building. She said she knew that boy – had seen him wandering around the reservation - knew he didn’t have parents that cared about him. She said “I wanted that boy”. She told her husband to pull over. Simple as that. The boy got in the car and went home with them. She raised him as though he was her own son without ever officially adopting him as far as I could tell. He had grown up to be a fine man, and became a

teacher. She told me that she had 8 children. Four by birth and four by “adoption”. All of her adult children worked serving others –as teachers, nurses, one as a physical therapist. This information vastly corrected my deficient empathy in the care of this patient. Most patients can provide you with *something* you can use to connect with them if you seek it out.

I have prejudices that I will probably never overcome. The only advice I can give is to be aware of your prejudices and do your best to find some way to love each of your patients. You cannot be a good doctor for your patients unless you care about them and are committed to helping reduce their suffering, whether their illness is their fault or not.

Humility

Humility is a characteristic that hangs in the balance with our pride, waxing and waning over the course of our career. We all try to achieve the self-confidence we need to make big decisions under stress, but maintain the humility to recognize and correct our mistakes and accept the help of others. I learned an important lesson about my own pride and lack of humility by observing pride get the best of one of mentors.

When I was a resident in the ICU in the mid 1980s, I was on call under the supervision of my mentor and hero who had been an attending for about 3 years at that time. We got called to the bedside of a patient on mechanical ventilation who was suffering acute shock. We both stood by the bedside trying to figure out what was going on as the nurses got IV fluids and pressors started. The patient continued to deteriorate, and my attending called for a chest X-ray to rule out pneumothorax. As we waited for the radiology tech to arrive, the patient rapidly deteriorated. I suggested that we put a chest tube in without waiting for the x-ray, but my attending said no – we should wait. We waited. The patient continued in a downhill spiral, and coded about 10 minutes later, just after the X-ray finally was taken. He did not survive the code. The CXR showed a pneumothorax.

I don't know what thoughts are in other's minds, and I sometimes unfairly project my own tendencies onto others. But I have interpreted this experience based on my own struggle with pride. I have an immediate tendency to say “No” to any

suggestion made by an intern or resident in regards to patient care. I think this tendency comes from an unhealthy pride and desire to always be the one to come up with the smart idea. It's a little bit humiliating as an attending to have someone in training beat you to the punch. It typically goes like this: intern makes reasonable suggestion; 2) I reject it and verbalize every reason I can think of why it's a bad idea, (as though I had already considered and discounted it); 3) then I walk off by myself, realize the idea was a good one, and figure out a way to implement it without losing too much face. This last part is usually easier than I think it's going to be, since the environment in which I work is mostly about doing the right thing for the patient rather than who gets credit. Even though this whole process probably seems ridiculous, it has helped me take advantage of the good advice of others many times over the years.

The nurses have been a HUGE source of good decision-support for me. But their good advice can only be effectively sought and put to advantage with the proper humility. I once witnessed two attending physicians enter a patient's room, one right after the other. The first was called to the bedside by a veteran ICU nurse with 25 years of experience because she felt the patient "just didn't look right". Objectively though, nothing much seemed to be going on – the patient's vitals hadn't changed much, and his morning labs and CXR looked OK. The first attending, a pulmonary critical care specialist, pointed this out, and left the patient's bedside just as the second attending arrived. Although the second physician shared uncertainty about what was going on, they felt uneasy about leaving the bedside when the nurse felt something bad was brewing. They examined the patient carefully, noting that the legs had mottled. The second physician reordered labs and the CXR, which revealed a tension pneumothorax. A chest tube was placed, and the patient recovered. Over the years, the nurses have covered for my shortcomings and given me invaluable advice many times. I have also probably missed many opportunities in situations in which nurses didn't think I would listen to them, and therefore kept their good ideas to themselves. I try to teach my fellows that one of the most important parts of being a good ICU doctor is to treat the nurses with respect and get them in the habit of expressing

their opinion by asking for it often. Doesn't mean you always have to take their advice, but it's a serious handicap to not at least hear it.

Overall Attitude

Probably the most important aspect of professionalism is the attitude you take to the patient's bedside. If you're in Critical Care, or in almost any other field of Medicine, you have potentially the most privileged and fulfilling professions in the world. The most frustrating, user-unfriendly EMR in the world doesn't change that. So don't let anyone tell you otherwise. Patients, families, nurses in the hospital *want* to be able to look up to you. They want you to be the one who can make things better. Can you think of any other profession with more chances to be an angel to someone who is facing one of the toughest days in their lives? The care you give a patient or their family are likely to be remembered by them for a long time to come. You have incredible leverage to benefit them and a unique opportunity to have a lasting positive effect on their lives. Whether you treat them well or poorly may affect them profoundly, maybe for the rest of their life. I don't think it's going too far to think that it even may affect how they treat others, because when people perceive the world as a kind place, it often becomes easier for them to act in kindness to others.

This is the attitude I think we should bring to each workday.

In any situation that we are faced with, there is good that can be done.

Our job is to find it, and make it happen.

Recently, I've seen doctors do a number of things that "weren't in their job description" – these are the things patients and their families will remember long after they've forgotten strictly "medical" aspects of their care. One of my partners took a patient on life support out of the hospital into our lobby courtyard at night to see the stars. Another invited a recovered patient to come with her and give a talk about the importance of nurses to her son's third grade class. One physician arranged to have a dying patient's dog snuck-in for a visit, obviously against hospital rules. Another went out to a camper in our parking lot, in which one of our patients wife and daughter were staying, to fix a plumbing leak. Consider yourself as the good guy or gal – this will enrich everyone's life, starting with your

own. One of my mentors keeps a picture of batman in his office to remind him of this.

One more memory about attitude:

Five years ago, I received a call from our transfer coordinator. I was being asked to assume the care of a patient in transfer who was in a very dismal situation. She was 36 years old, married, the mother of four boys. She was pregnant with a 22-week baby - too young to survive birth. She had recurrent breast cancer with metastases to her lungs and brain. She had lapsed into a coma and was intubated on mechanical ventilation, as edema around her brain tumor increased. I covered my face in my hands as I took in this information, and I remember thinking how much I hated certain aspects of my job. There didn't seem to be any reasonable chance for this transfer to turn out anyway but terrible. I resented being put in the position in which I would have to shoulder the emotional burden of bringing her family through their bereavement. If the patient's family had known what was on my mind, there's no way they would have allowed me to take care of her.

I went through the motions when the patient arrived, gleaned some more history. Her name was Samantha. Her cancer had recurred at 10 weeks pregnancy. Her oncologist had offered her chemotherapy and hormonal therapy, but warned her that these treatments were risky for the baby. Samantha decided to sacrifice her own treatment for the welfare of her baby. She had been hoping for a girl.

On the fifth hospital day Samantha suffered brain death secondary to cerebral edema, related to her brain metastasis. Her baby was only 23 weeks old – a gestational age with only a 40% survival rate. After consultation with her husband, we carried forth a plan to keep Samantha's heart beating as long as possible, until her baby could mature enough to survive. Over the next 7 weeks, we maintained Samantha's blood pressure, gas exchange and temperature. We replaced hormones made by the hypothalamus of the brain and pituitary gland. Fifty days after her mother Samantha's death, healthy baby Samantha was born.

I feel rotten about my initial bad attitude looking back over this case – which turned out to be one of the most fulfilling of my career. That’s one of the great things about critical care. Sometimes the most discouraging beginnings can entail unforeseen potential for you to accomplish good as a physician. When you have experiences such as this, hang on to the memories (this is one of my selfish reasons for writing this series). Remembering miracles that you are witness to will help you fight discouragement which is the enemy of the proper professional attitude as an intensivist.