

Virtual Mentor

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FROM THE EDITOR

Seven Minutes to Midnight

Audiey Kao, MD, PhD

*The only hope for the future lies in cooperative international action
To survive in the world we have transformed, we must think in a new way.
John Polanyi, Nobel Laureate in Chemistry (1986)*

On February 27, 2002, the Board of Directors of the *Bulletin of the Atomic Scientists* advanced the "Doomsday Clock" from 9 to 7 minutes before midnight.¹ Founded by a group of scientists involved in the Manhattan Project, the *Bulletin* periodically assesses the geopolitical climate to determine how close humanity is to nuclear Armageddon. Since the clock was established more than a half century ago, this is the third time that the hands have moved forward, towards an unthinkable, self-inflicted extinction of humanity.

While some of the factors considered by the *Bulletin* arise from the immediate aftermath of the terrorists attacks on the US, many of the global problems that contribute to international instability are fueled by longstanding social and economic disparities between rich and poor nations—abject poverty, poor education, and lack of health care. Given these global challenges, how do we begin to think and act anew, as Polanyi implores, so as to foster international cooperation and collaboration in addressing the root causes of humanity's despair and fanaticism. More specifically, how do we as physicians meet our social obligations and serve as a positive force in addressing the multitude of issues that restrain the flourishing of all peoples.

In thinking and acting anew, physicians are bound in their response by a common heritage of caring for the sick and the suffering. Dating back more than 2½ millennia, the moral foundations of Western medicine have their origins in the Hippocratic Oath, an ethic that is primarily beneficence based. This beneficence model of the "good doctor" has prominently influenced the ethical course of American medicine. Benjamin Rush, a signer of the Declaration of Independence and a founding father of US medical education, championed a moral philosophy of medicine that related virtues and duties to the sound practice of medicine. In forging the world's first national code of professional ethics—the 1847 *AMA Code of Ethics*—Drs. John Bell and Isaac Hayes were inspired by the Hippocratic tradition to recapture in this national code "a sense of ethical obligation rising superior . . . to considerations of personal advancement".² For contemporary advocates of virtue ethics such as Edmund Pellegrino and David Thomasma,

benevolence and fidelity to trust are as necessary for the practice of good medicine in the present as they were in the past.³

Despite recent theoretical and practical attacks on the Hippocratic ethic,⁴ I contend that medicine's legitimate status remains centered on an ethic of beneficence and is explicitly reflected in medicine's social contract with humanity. In non-Western medicine, beneficence also serves as a central moral tenet by which physician ethics are formulated and judged. In Islamic medical ethics, for example, greater emphasis is placed on beneficence than on autonomy, especially at the time of death. The saving of a life is considered one of the highest merits and imperatives in Islam. According to the Quran (5:32), ". . . and who so ever gives life to a soul, it shall be as if he had given life to mankind altogether".⁵ Thus, any intentional efforts to hasten death such as euthanasia are considered murder and are not permissible. In China, the development of medical ethics was greatly influenced by Confucianism. The core of Confucian ethics is benevolence, which means "to wish people well".⁶ The practice of Chinese medicine is considered a humane art, and a physician must be loving in order to treat the sick and heal the injured. Given the inherent vulnerability created by illness and disease irrespective of color, class, or culture, the exercise of genuine beneficence has endured as an ethical cornerstone of medical practice that binds all physicians over time and across cultures.

The existence of a common ethical paradigm that guides physician obligations and conduct from the East to the Middle East to the West has fostered the concept of a social contract between medicine and society. Generally, social contract theory is the view that ethical conduct is founded on normative agreements that benefit those who make the agreement. In medicine, the social contract has traditionally been defined by the idea that physicians are granted privileges, such as prestige, status, and financial rewards, with the assumption that they will in turn focus on service and altruism.⁷ However, the social contract is not a legally binding document, nor are the terms of agreement drafted with direct input by both parties. Rather, the social contract is an explicit covenant that imposes obligations and accountabilities on one of the parties to the contract—members of the medical profession.

Enjoying social legitimacy and privilege, physicians have corresponding, inescapable duties to all of society's members. The obligations and duties reflect the 4 "hats" that physicians wear. The first 3 represent physicians in their traditional roles as healer, scientist, and teacher. The fourth, increasingly relevant in today's civil society, is the physician's role as citizen.

Society expects *physicians as healers* to treat the sick and injured with competence and compassion, and without bias. With increasing diversity of our patient population, physicians must apply their knowledge and skills with objectivity and fairness irrespective of race, religion, nationality, social standing or political affiliation. At the same time, physicians must provide such care when needed, though doing so may put them at risk. The beneficence-based idea that physicians have a duty to treat the sick even though it puts their own lives at risk, is relatively

recent. It was not a Hippocratic ideal, and, in fact, physicians who failed to flee epidemics were considered foolhardy. Beginning in the seven-teenth century, ideals of Christian charity combined with notions of gentlemanly honor and *noblesse oblige* to transform the vice of foolhardiness into a virtue. According to Robert Baker, the first clear statement of a professional duty to treat appears in the 1847 *AMA Code of Ethics*. It states that "when pestilence prevails it is [physicians' professional duty to the public] to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives".⁸

Society expects *physicians as scientists* to work freely with colleagues to discover, develop, and promote medical and public health advances that ameliorate suffering and contribute to human flourishing. Sadly, there have been times when physicians have failed to live up to this obligation. In the Tuskegee experiments conducted by US Public Health Service, African American men in the late stages of syphilis were denied treatment with penicillin so that physician-scientists could better understand the course of this disease.⁹ In Nazi Germany, physicians as agents of the state engaged in unspeakable human experimentation and implemented a sterilization law for persons with a variety of mental and physical disabilities. In response to such heinous acts perpetuated under the guise of biomedical research, the Declaration of Helsinki, which explicitly spelled out human subjects' protections for the ethical conduct of research, was ratified and adopted by medical professional societies across the world in 1964.

Society expects *physicians as teachers* to train and mentor those who follow them for they are the future of a caring medical profession. Institutions of medical education and training are the beneficiaries of much public support. Because of this, physicians are obligated to act with care and earnestly in the education of students and doctors-in-training. In addition to educating the next generation of healers on their ethical obligations as professionals, society expects physicians to educate the public and polity about present and future threats to the health of humanity. Given great public anxiety and fear raised by new threats of bioterrorism, the profession's duty to provide accurate and relevant information is more important than ever to inoculate against widespread public chaos and panic.

Society expects *physicians as citizens* to respect human life and the dignity of every individual. Physicians must refrain from supporting or committing acts of prejudice and violence, and condemn any peer who would engage in such acts. Since many factors that influence humanity's health are not medical in nature, physician advocacy for social, economic, and political changes that ameliorate suffering and contribute to human flourishing is essential. As physicians are widely recognized to uphold the ideals of objectivity and compassion, they can reach and assist peoples in need across cultural, religious, and ideological divides. With such access, some have become targets of violence, and to those physicians who labor at the outskirts of human safety and well-being, I salute your courage and dedication. For others who want to help, the AMA is preparing to launch an initiative to care for humanity, and I hope that all of us will respond to this call to action.

Through the centuries, physicians have fulfilled their obligation to care for the sick and the suffering. Today, the medical profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humanity. Only by acting together across geographic and ideological divides can we overcome such powerful threats. We must act now because time stops for no one.

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

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CASE AND COMMENTARY

Patient Care and Student Education, Commentary 1

Commentary by Caleb Alexander, MD

Case

Dr. Harvey was admitted yesterday to the general medical service of a teaching hospital. This is his third admission in 8 months. One prior admission was, like this one, due to exacerbation of long-standing chronic obstructive pulmonary disease (COPD). The other admission was prompted by dizziness and fainting brought on by his poorly controlled diabetes. Mr. Harvey is 57 years old and African American. Management of his health is complicated by obesity and (as he confessed to Miss Rogers, the third-year medical student who interviewed him when he arrived on the unit) his continued smoking.

A chest X-ray ordered in the emergency department before Mr. Harvey's admission shows results consistent with pneumonia. Blood culture results are not back yet. Antibiotic treatment administered intravenously is indicated, but Mr. Harvey's peripheral circulation is poor and several attempts this morning to place the IV in his arms failed. Becoming somewhat irritable with the attempts, Mr. Harvey complained that, "No one in this place can ever find my veins."

Dr. Gage, the senior resident, decides that a subclavian central line should be placed to gain intravenous access. Then antibiotics, fluids, and other medications, if needed, can be easily and effectively administered without continuing to poke at Mr. Harvey's peripheral veins.

Dr. Gage is supervising 2 third-year medical students who are in week 6 of their 8-week internal medicine rotation. The students are Mr. Crane and the previously mentioned Miss Rogers who has interviewed Mr. Harvey. Dr. Gage has established good working relationships with both students, who are highly motivated and competent. Dr. Gage takes her role as educator seriously and wants to be confident that students gain the experience and, to the extent possible, the skills they should while under her supervision.

Mr. Crane has successfully placed central lines on several occasions during his rotation. Miss Rogers has been unsuccessful on 2 attempts with different patients. Each time Dr. Gage stepped in (using her 3 sticks and you're out rule). For a couple of reasons, Mr. Harvey is a good patient for Miss Rogers next attempt. His condition is not emergent; he is accustomed to the teaching hospital routine, and has taken Miss Rogers' into his confidence. He considers her to be "on his side." On the

other hand, his obesity makes the procedure more difficult than usual. Because of his multiple health problems, complications, should Miss Rogers' puncture his lung, would be life-threatening. He is already irritable about the inability of those at this hospital to "find his veins." Mr. Harvey is a Medicaid patient, and Dr. Gage is sensitive to the potential for Medicaid patients to shoulder more than their share of student and intern "practicing." Were she acting solely as clinician and not as educator, Dr. Gage would ask Mr. Crane to place the line.

Miss Rogers knows that she should succeed at placing a central line before completing her internal medicine rotation, and time is running out. She is on her way in to inform Mr. Harvey about the procedure and its risks and to obtain his consent for it. She identified herself as a student when she first introduced herself and interviewed him. They seem to communicate well. If Dr. Gage asks her to attempt to place the line, she wonders, how much will she have to tell Mr. Harvey about her past attempts. When she goes into Mr. Harvey's room, he is chatting with his grown daughter who has just arrived to see what's going on with her father.

Three commentaries on this case follow.

Commentary 1

Mr. Harvey is a patient with emphysema who has now been diagnosed with pneumonia and admitted to a teaching hospital. We are informed that the placement of a central venous catheter is clinically indicated, and at issue is the question of *who* is to place it and *under what circumstances*. This case illustrates a common dilemma for house officers and attending physicians in teaching hospitals. The primary challenge is how to best balance the potential tension that exists between the goals of providing the best standard of care to individual patients and fostering a learning environment where medical students and residents acquire the knowledge and technical skills that are critical to their developing into competent physicians. What degree of excess risk is acceptable for a patient to assume in order to offer training for novice students? Can this excess risk be quantified in particular circumstances? What are the factors that mediate this increased risk and how can they be minimized? Do the principles of informed consent require that Mr. Harvey be advised of the identity and technical competency of the person who will place the central line?

See One, Do One, Teach One.

Teaching hospitals serve an important function within our society by offering physicians-in-training the opportunity to learn the skills that they must have to become competent practitioners while attempting to provide an exceptional standard of care to individual patients. Society has an interest and investment in this process.

Naturally, achieving technical competency among physicians is a gradual process marked by several transitions. Medical students begin with lectures and anatomy lab and only after their first years in medical school do they move to the clinical

setting where they participate directly in patient care. While models exist to help those in training achieve technical proficiency at different procedures (eg, practicing suturing on fruit) few would argue that these suffice at providing the exposure necessary to achieve competency.

The oft quoted expression "See one, do one, teach one" is used as a guide for many hesitant physicians-in-training as they consider their preparedness to perform bedside procedures. While the ratio of 1:1:1 is not steadfast, the transitive nature of education that it reflects is noteworthy. Those with less experience first observe a procedure, then perform one, and finally reach a stage of teaching the procedure to the next person with less experience as the cycle begins anew.

Returning to the case, there are 2 principal issues that Dr. Gage, the senior resident, must consider. First, who is to attempt the central line placement? Second, what information should the process of informed consent include? In considering these issues, Dr. Gage should consider the potentially competing goals of maximizing patient safety while fostering an educational climate for her trainees.

Who Is to Attempt Central Line Placement?

Several factors are important for the team to consider as they make this decision. What are the student's and house officer's comfort with the student performing the procedure? How acutely ill is the patient and how quickly is the procedure required? What are the patient's and family's wishes regarding who is to perform the procedure? How technically difficult is the procedure? Finally, what are the likelihood and severity of potential complications and how are these modified by the greater technical experience of more senior physicians? While perhaps the least quantifiable, the most important global measure that a senior house officer should consider in deciding who is to perform a procedure is his or her own intuition as to the appropriateness of the teaching moment. Unusual amounts of anxiety, a feeling of haste, and poor technical details (eg, lighting, height of bed, position of patient, failure to identify important physical landmarks) are the best indicators of a highly risky procedure. In this case, the combination of Mr. Harvey's comorbid conditions, the life-threatening nature of a potential complication (pneumothorax), and Miss Rogers' own perceived pressure to successfully place a central line before her rotation ends, each should give Dr. Gage pause regarding the wisdom of having her attempt the procedure at the current time.

What Should Mr. Harvey Be Told?

Let us assume that Dr. Gage and Miss Harvey carefully consider the factors discussed above and conclude that indeed this is a good opportunity for Miss Rogers to attempt the procedure. What information should Mr. Harvey be told in order to provide an informed consent? Standard components of informed consent, such as the indications, risks, benefits, and alternatives to the procedure can be discussed. The key question in this setting is how much information Mr. Harvey needs to be provided regarding the identity and technical competency of the person who is to perform the procedure. Not telling Mr. Harvey about who is to perform

the procedure would deny him important information that might modify his decision. On the other hand, to tell him who is to perform the procedure while denying him knowledge of that person's technical competency seems inadequate. How then would he use the information regarding this person?

The challenge to the team is that assessing technical competency and talking about it with patients can be a difficult task. These challenges are magnified by such other common obstacles to informed consent as the acuity of illness that often characterizes the hospitalized patient. It is arguable whether a detailed discussion of Miss Rogers' prior experience with central line placement (ie, that she has failed in 2 prior attempts) is necessary. First, such discussion risks raising disproportionate anxiety on the part of both Mr. Harvey and Miss Rogers regarding the procedure. Second, it is unclear whether Mr. Harvey (or the medical team) has the requisite knowledge to interpret the information provided—how common is it to fail an attempt at catheter placement, how does this likelihood change over someone's training and across different patients, what are the implications of a failed attempt with regard to potentially life-threatening complications such as pneumothorax?

Rather than discuss Miss Rogers' prior experience with central line placement, Mr. Harvey should be informed of the proposal that Miss Rogers, a medical student, will be the person attempting the procedure under the close supervision of Dr. Gage. Additionally, any questions that Mr. Harvey may have about Miss Rogers' experience should be addressed honestly and directly.

The Bottom Line

Virtually all senior house officers will be challenged during their training to balance the health care needs of their patients with the educational needs of their junior colleagues. Sensitivity to the mediators of procedural risk, in conjunction with an adequately thorough informed consent, should be the trainee's primary guide in achieving this balance.

Caleb Alexander, MD is a post-residency fellow in the Robert Wood Johnson Clinical Scholars Program. He is working at the University of Chicago.

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CASE AND COMMENTARY

Patient Care and Student Education, Commentary 2

Commentary by James F. Bresnahan, SJ, JD, LLM, PhD

Case

Dr. Harvey was admitted yesterday to the general medical service of a teaching hospital. This is his third admission in 8 months. One prior admission was, like this one, due to exacerbation of long-standing chronic obstructive pulmonary disease (COPD). The other admission was prompted by dizziness and fainting brought on by his poorly controlled diabetes. Mr. Harvey is 57 years old and African American. Management of his health is complicated by obesity and (as he confessed to Miss Rogers, the third-year medical student who interviewed him when he arrived on the unit) his continued smoking.

A chest X-ray ordered in the emergency department before Mr. Harvey's admission shows results consistent with pneumonia. Blood culture results are not back yet. Antibiotic treatment administered intravenously is indicated, but Mr. Harvey's peripheral circulation is poor and several attempts this morning to place the IV in his arms failed. Becoming somewhat irritable with the attempts, Mr. Harvey complained that, "No one in this place can ever find my veins."

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Mr. Crane has successfully placed central lines on several occasions during his rotation. Miss Rogers has been unsuccessful on 2 attempts with different patients. Each time Dr. Gage stepped in (using her 3 sticks and you're out rule). For a couple of reasons, Mr. Harvey is a good patient for Miss Rogers next attempt. His condition is not emergent; he is accustomed to the teaching hospital routine, and has taken Miss Rogers' into his confidence. He considers her to be "on his side." On the

other hand, his obesity makes the procedure more difficult than usual. Because of his multiple health problems, complications, should Miss Rogers' puncture his lung, would be life-threatening. He is already irritable about the inability of those at this hospital to "find his veins." Mr. Harvey is a Medicaid patient, and Dr. Gage is sensitive to the potential for Medicaid patients to shoulder more than their share of student and intern "practicing." Were she acting solely as clinician and not as educator, Dr. Gage would ask Mr. Crane to place the line.

Miss Rogers knows that she should succeed at placing a central line before completing her internal medicine rotation, and time is running out. She is on her way in to inform Mr. Harvey about the procedure and its risks and to obtain his consent for it. She identified herself as a student when she first introduced herself and interviewed him. They seem to communicate well. If Dr. Gage asks her to attempt to place the line, she wonders, how much will she have to tell Mr. Harvey about her past attempts. When she goes into Mr. Harvey's room, he is chatting with his grown daughter who has just arrived to see what's going on with her father.

Commentary 2

Dr. Gage, the senior resident, and 2 third-year medical students are challenged in their dedication to the best interests of their patient, Mr. Harvey; it is an ethical challenge.

Although Mr. Harvey's care is reimbursed under the Medicaid program, the immediate challenge in this case does not derive from the pressure of reimbursement entities to diminish the expense of caring properly and well for their patient, though such pressure is not unknown these days. The subclavian line Mr. Harvey needs for antibiotic therapy will be provided. But the constraints on providing adequate medical education during this era when patients are moved more and more briskly out of acute care are a factor in this ethical challenge. For, though now in week 6 of her 8-week junior medicine rotation, Miss Rogers has not yet successfully placed a subclavian line. Miss Rogers, however, has been involved directly with Mr. Harvey, and has his trust—as frequently happens with a third-year student who has time to get to know a patient more thoroughly in a short time than is possible for most doctors during the rest of their professional lives.

Dr. Gage now ponders whether to assign the task of placing the line to Miss Rogers who has failed in her 2 previous attempts to do this, to turn it over to the other medical student, Mr. Crane, who has several successful attempts to his credit, or to take on the task herself.

Mr. Harvey's compromised situation gives pause to this care giver team leader's preoccupation with educational considerations. Mr. Harvey needs a steady hand and practiced eye because his fragile medical condition combined with his obesity makes a serious error in placing the subclavian line dangerous, even life-threatening.

There are reasons to believe that Dr. Gage and Miss Rogers might, by judicious restraint in their use of language, obtain Mr. Harvey's "consent" to let Miss Rogers have a go at him. On the other hand, Mr. Harvey's daughter, who is present now and concerned about him and the quality of the care he is receiving, may well foil such a ploy—and do it to the considerable embarrassment of the young physician and her students. (The possibility that the team regards Mr. Harvey, due to his non-compliance, as "deserving" to be experimented on should, of course, not even be entertained.)

This situation provides a grand opportunity for Dr. Gage to teach a very practical lesson in clinical medical ethics of the traditional kind—the kind that puts the good of the patient above all other considerations. Dr. Gage should call Mr. Harvey's attending physician and, in the presence of the 2 students, the 2 physicians should determine which of them can place the subclavian line most safely for this vulnerable patient with serious medical problems who trusts in his care givers' faithfulness to his medical best interests.

This clinical lesson—patient interests come first—may, in days and years to come, prepare us to handle appropriately the more insistent pressures we will encounter from the reimbursement bean-counters when they suggest that we compromise good clinical care of patients in the interest of dollars, not student education.

James F. Bresnahan, SJ, JD, LL.M, PhD is professor emeritus, Medical Ethics & Humanities, at Northwestern University Medical School.

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CASE AND COMMENTARY

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Commentary by Arthur R. Derse, MD, JD

Case

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Commentary 3

If today's medical trainees do not learn techniques such as medical interviewing, physical examination, and medical and surgical procedures through practice with real patients, not only will these trainees lack the necessary training, but tomorrow's physicians will not have the skills to care for all of us. Nonetheless, patients should not have trainees practicing these procedures without their knowledge and consent.

This case raises 3 important issues: Under what circumstances should a trainee be allowed to practice a technique? What should be disclosed in order for a patient, or patient representative, to give adequate consent? How can the burdens of medical training be distributed equitably among patients?

First, under what circumstances should a trainee practice a technique on a patient? Trainees should practice a technique in cases where the danger from their mistakes does not pose more than a minimal incremental risk over the inherent risk to the patient. Where the risk is minimal (eg, the patient is stuck with a needle for an IV without success and has additional pain from the attempt), there should be no impediment to a trainee who has been properly educated in the procedure being permitted to practice the procedure, even without supervision.

Where the inherent risk of the procedure is moderate (eg, placing a central line in someone with normal clotting abilities, with the risk of internal arterial bleeding or pneumothorax, with resolution of the complication possible by pressure or chest tube insertion) and there is minimal incremental risk in placement by an inexperienced individual, the procedure should be closely supervised. These complications can happen in the best hands, and the minimal incremental risk at the hands of a trainee should be permitted.

When the inherent risk of the procedure is severe (eg, intubation, with inherent risks of anoxia if the patient is not properly intubated), even with minimal incremental risk in attempts by inexperienced trainees, supervision should not only be close, but the trainee must have sufficient experience in other patient care knowledge and experience to warrant the intervention (eg, animal and mechanical model training or successful attempts in patients who are ideal candidates under optimal circumstances).

In the case of Mr. Harvey, the risks of placing the central line as described above are moderate, assuming that Ms. Rogers has been properly educated in the procedure, these attempts may be judged to be a minimal increment over the normal risks of the procedure, and hence permissible.

The second question is what should be disclosed to the patient? Certainly, most patients who come to teaching hospitals are aware that there are medical students, residents, and fellows in the hospital who are being trained in medicine and its subspecialties. Admission forms that patients sign explain that they may be treated by these trainees. Whether there is a legal requirement that the trainees identify themselves as trainees (and inform the patient that they are still learning the procedure) is not a settled question. Certainly the law of informed consent requires that physicians inform patients of the material risks inherent to the proposed procedure, though, in almost all jurisdictions, physicians who have been trained and are in practice are not legally required to disclose their past experience or "batting average" in order for consent to be informed.

Nonetheless, should the ethical standard be different? If the trainee is inexperienced in the procedure, this should be disclosed. Beyond the basic fact of inexperience, there should be no ethical mandate to disclose past experience with the procedure, though certainly if a patient or anyone else specifically asks the physician about his or her experience, the physician should answer truthfully. And trainees should identify themselves to patients in all circumstances. In this case, the trainee, Ms. Rogers should and did identify herself as a student.

Third, how can the burden of training be born equitably? Mr. Harvey is African American and a Medicaid patient, and care must be taken to make sure that patients in a teaching hospital are not selected inequitably for teaching practice. This is why all patients in a teaching hospital should be eligible for trainees practicing procedures.

It should be noted that studies have shown that patients do not get inferior care because they are being treated at a teaching hospital, and many state-of-the-art treatments are developed and provided at teaching hospitals. Nonetheless, patients may prefer to forgo treatment by trainees. If the patient expresses this preference, it should be dealt with honestly. Some institutions may not offer patients the choice to refuse.

In this case Dr. Gage thinks that were she acting solely as a clinician, and not as an educator, she would ask the more experienced and successful student to place the line. I would argue that if Dr. Gage were truly acting solely as a clinician who wanted the best for her patient, she would forgo both students for her own, more experienced, hand, since it is more likely that Dr. Gage with her experience, would be successful more often than Mr. Crane. Yet, just because Mr. Crane has been successful, he may not yet have learned how to avoid mistaken placement of the line. And without practice, Ms. Rogers will have no more experience and will be unable to perform the procedure when the next patient needs it, and at some point in her training, a patient will need it emergently and she will be the only one available immediately. And that patient would be better off with a well-trained physician. Finally, because Mr. Harvey has poor peripheral veins, he could well be the next patient needing a well-trained physician.

Should Ms. Rogers inform Mr. Harvey that she is inexperienced and learning the procedure? Yes. How much should Ms. Rogers tell him about her past attempts? Nothing, unless he asks, and then she should answer truthfully. Since she is a student, her past attempts are no indication of her future performance. She is learning to avoid her past mistakes.

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CASE AND COMMENTARY

Overriding Patient Confidentiality

Commentary by Erica Ozanne Linden, JD, MPH

Case

Sarah Smith is a 42-year-old woman with a family history of breast cancer. Her mother died of breast cancer at age 39, her grandmother at 42, and a maternal aunt at 45. Sarah herself has a 20-year-old daughter. She is concerned about her own risk of breast cancer and visits her gynecologist, Dr. Walsh, to discuss her options. Dr. Walsh takes Sarah's family history and informs her that there is a genetic test that can be used to screen women to identify those at risk for breast cancer. Sarah's doctor explains to her that women who have mutations in the BRCA1 or BRCA2 genes have a substantially increased risk of developing breast cancer.

Sarah asks Dr. Walsh whether she should be tested for one of the mutations. Dr. Walsh educates Sarah about breast cancer genetics and thoroughly discusses with her the risks, benefits, and limitations of the genetic testing. Some of these risks include a potential negative impact on a patient's medical and life insurance, employment discrimination, and emotional and psychological distress.

As part of her counseling, Dr. Walsh thoroughly explains to Sarah that the management options for women identified as having mutations in the BRCA1 or BRCA2 genes include close monitoring, chemoprevention, or prophylactic surgery, including prophylactic mastectomy. Dr. Walsh also explains that none of the treatment options guarantees that the woman will avoid getting breast cancer, and tells Sarah that the option of a prophylactic mastectomy is highly controversial because of its drastic nature.

After lengthy consideration, Sarah decides to undergo the testing. Dr. Walsh orders the tests for BRCA1 and BRCA2 mutations and finds that Sarah has a mutation of the BRCA2 gene. Dr. Walsh then informs Sarah of the test results. Sarah tells her doctor she wants to keep her test results private, because she does not want any of her family members to know the results. She does not want them to worry or treat her differently. She says there is no reason for her life to change unless she develops cancer. She will agree to the preventive measures that Dr. Walsh advises, excluding mastectomy, but she does not want anyone to know that she "might" have cancer in the future. "Everyone *might* have cancer in the future," Sarah says.

Dr. Walsh doesn't know how to respond. Courts have split on whether to create an exception to the physician-patient privilege when revealing genetic information to a

third party may help a patient's family avoid harm. In *Pate v Threlkel*, 661 So.2d 278 (Fla. 1995), the Florida Supreme Court held that a physician has a duty to warn a patient of the genetically inheritable nature of his or her disease, but that the duty to warn is satisfied by telling the patient.

In a similar case, *Safer v Pack*, 291 NJ Super. 619 (NJ Super. Ct. App. Div.), a New Jersey Superior Court reached a different decision. In *Safer*, the Court held that the duty to warn may *not* be satisfied by simply informing the patient and may require that "reasonable steps" be taken to assure that the information reaches the parties at risk. However, the court did not specify what those "reasonable steps" might be.

See what the AMA *Code of Medical Ethics* says about this topic in Opinion 5.05. Confidentiality. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.

Questions for Discussion

1. Does Dr. Walsh have an obligation to inform Sarah's daughter of her mother's test results and explain to her that she may also have an increased risk for breast cancer?
2. Given that case law is not explicit on what physicians should do, how should Dr. Walsh proceed in this case if Sarah refuses to tell her daughter?

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PERSONAL NARRATIVE

Razia's Question

Naheed Rehman

Her sunken eyes and the many lines on her face told a tale of sadness and loss. Her bowed head reflected the weariness of years of struggle, yet there was a resilience in this woman unlike any I had ever seen.

As I sat with Razia in the only covered room in her small house, I came to appreciate that she was a woman whose life could not have been more different than mine. Forty one years-old, Razia was the mother of 9 children whom she was struggling to support in an urban slum of Karachi, Pakistan. Razia's days and nights were spent making incense which she packaged and sold in local markets for a tiny profit. Each sale contributed to the very modest income of her household, of which she was the main breadwinner. Razia stated proudly that she'd been able to support 5 of her children through grade school and expressed dreams that they would find honorable jobs. When I asked about the other children, she stated that they'd dropped out to work so that they could help make ends meet at home. There was a sadness in her voice as she said this, one that reflected her sense of regret and guilt for having stolen their futures from them. Such were the compromises of poverty.

Razia's lived experience was one of many I came to understand in my capacity as a researcher in Pakistan 2 years ago. A student in the UC Berkeley-UC San Francisco Joint Medical Program, I had ventured to Pakistan to understand the linkages between poverty and health for my medical master's thesis project. Specifically, I sought to understand the social impacts and constraints of microcredit programs in alleviating poverty.

Microcredit had come to my attention a few years ago for its remarkable success in enhancing livelihoods of poor women in Bangladesh. The principle of microcredit was that the disbursement of small, collateral-free loans to poor women and men could allow these individuals to start small businesses that could support their families. From the earnings of such businesses, the poor could both repay their loans and save enough money to provide food, shelter, and clothing for their families. Data I'd studied from Bangladesh revealed that programs like that of the Grameen Bank were lending money to more than 2,000,000 women and achieving a 98 percent repayment rate. The recipients of microcredit had been found to achieve better nutrition, physical health outcomes, and educational outcomes than their peers in the same communities. In some cases, daughters of microcredit recipients were even able to matriculate in college, dramatically enhancing the chances of

their own financial security and that of their families. The subordinate status of women in South Asia made the success of women-targeted programs all the more heartening.

My own research in Pakistan aimed at understanding the dynamics of microcredit participation in an urban setting. My study participants were men and women who had taken loans from a small community-based organization in Karachi known as the Orangi Pilot Project. Conversations with these men and women taught me that the impacts of microcredit in their lives could not be understood in black and white terms. Razia's experience, cited above, was one very clear example of this ambiguity. On the one hand, Razia spoke of measurable improvements in food security and household income made possible through microcredit-enhanced income. The thick floormat upon which we sat during the interview had been purchased through savings from a microloan. Yet there were struggles in Razia's life that a small loan could not penetrate. The loan could not generate enough profit to tide Razia's family over during the numerous recessions common to Pakistan's unstable economy. It could not protect Razia's family from ethnic violence that erupted episodically in her community, endangering the lives and property of many unlucky people caught in the way. There wasn't enough profit from her loan to allow all of Razia's children to attend school. Two of her daughters had left ninth grade to help their mom with the family business, recognizing that she'd been preoccupied with saving money to pay for their dowries. Finally and most critically, no loan could replace Razia's recently deceased husband, whom I learned had died only weeks before our interview from heart disease. When I gently inquired if her husband had been ill a long time, Razia nodded yes. She spoke of the enormous stress, anxiety, and even depression he suffered trying to support his family through some of Pakistan's most economically troubled times.

Feeling the need to end our interview, I apologized to Razia for disturbing her so soon after her husband's death. I hadn't known, I explained, and quickly gathered my materials ready to leave Razia alone. I felt guilty about the respect afforded me as a guest, one so considerable that it prevented Razia from refusing my query to speak with her in the first place. It surprised me, therefore, that she stopped me as I attempted to leave. She was determined to have her story known. Razia insisted that people like her were bountiful in Pakistan. If the poor in countries like mine could receive public assistance, access to public education, and minimal wages, why couldn't she? Didn't anyone care for people like her?

To this day I am disappointed with my incapacity to give Razia an answer she deserved, to assure her that she would be alright and that her children's futures would hold the hope of better prospects. Having studied development and globalization, having understood the growing gap between First World and developing countries, and having been sobered by the frequent incapacity of multilateral organizations like the United Nations to protect the interests of vulnerable populations, I felt a sense of powerlessness in my responses to her questions. There are no satisfactory reasons to explain why Razia could not expect

to receive financial support from her government, why there isn't adequate public education, access to health care, and low-cost housing in her community, and why medications needed to treat her during times of illness are so unreasonably expensive. My expressions of empathy for Razia's struggles and my promise to make recommendations to enhance delivery of microcredit to women like her were as much as I could deliver Razia during our brief time together. Yet I wanted, and still desire, to do more.

Health professionals deliver medical and spiritual care to people with a tremendous range of physical, psychological, and material needs. Whether working in public health clinics of the developing world or in world-class medical centers of the US, I wonder how often we pause to reflect on the complexity of the lives we touch, the extent to which the multiplicity of a person's needs are in fact intricately and inextricably interwoven. An appreciation for this complex nexus reveals the importance of contexts of justice, peace, and economic stability for the work we do in medicine. It also underscores the importance of physician participation and leadership in movements and initiatives to protect and promote the totality of human well-being, which include efforts in human rights, women's empowerment, social justice, and international development. For me, encounters with women like Razia fuel a drive to become a better doctor through the process of becoming a better global citizen. As I see it, medicine is a mission whose ultimate goal is the preservation of human dignity in every possible formulation.

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VIEWPOINT

How Many of Us Does It Take to Change a Light Bulb?

Audiey Kao, MD, PhD

How many psychiatrists it takes to change a light bulb?

A: Just one, but the light bulb has to really want to change.¹

Q: How many pre-med students does it take to screw in a light bulb?

A: 100. 1 to change the light bulb, the other 99 to stand around wondering why they weren't chosen.

A: 5. One to change the bulb and 4 to pull the ladder out from under him.

Q: How many surgeons does it take to change a light bulb?

A: None. Surgeons wait for a suitable donor and do a filament transplant.

Q: How many orthopedic surgeons does it take to change a light bulb?

A: None. They take out the socket instead. Since the light bulb doesn't work, you won't be using the socket anyway, and it will only cause you trouble down the line.

Q: How many chiropractors does it take to change a light bulb?

A: Only 1, but it'll take 9 visits.

Q: How many physiotherapists does it take to change a light bulb?

A: None. They give the dead bulb some strengthening exercises to do and hope it will be working a bit better the next time they see it.

Q: How many plastic surgeons does it take to change a light bulb?

A: A host. One to do the surgery and the rest to present you with options. "Now that you've decided on change, do you really want to keep that pear shape? We can take a few of those watts off, and lengthen that filament, and

A sneeze of allergists

A snooze of anesthesiologists

A murmur of cardiologists

A stain of histologists

A rash of dermatologists

An outbreak of epidemiologists

A vessel of heart surgeons

A clot of hematologists

A growth of oncologists

A gaze of ophthalmologists
A cast of orthopods
A squall of pediatricians
A dose of pharmacologists
A body of pathologists
A break of radiologists
A stream of urologists
A stone of nephrologists

A Code of Ethical Behavior for Patients³

1. Do not expect your doctor to share your discomfort.
Involvement with the patient's suffering might cause loss of valuable scientific objectivity.
2. Be cheerful at all times.
Your doctor leads a busy and trying life and requires as much gentleness and reassurance as possible.
Try to suffer from the disease for which you are being treated.
3. Remember that your doctor has a professional reputation to uphold.
4. Do not complain if the treatment fails to bring relief.
You must believe that your doctor has achieved a deep insight into the true nature of your illness, which transcends any mere permanent disability you may have experienced.
5. Never ask your doctor to explain what he or she is doing or why.
It is presumptuous to assume that such profound matters could be explained in terms that you would understand.
6. Submit to novel experimental treatment readily.
Though the surgery may not benefit you directly, the resulting research paper will surely be of widespread interest.
7. Pay your medical bills promptly and willingly.
You should consider it a privilege to contribute, however modestly, to the well-being of physicians and other humanitarians.
8. Do not suffer from ailments that you cannot afford.
It is sheer arrogance to contract illnesses that are beyond your means.
9. Never reveal any of the physician's shortcomings that have come to light in the course of your treatment.
The patient-doctor relationship is a privileged one, and you have a sacred duty to protect your physician from exposure.
10. Never die while in your doctor's presence or while under his or her direct care.
This will only cause the physician needless inconvenience and embarrassment.

Four Doctors Duck Hunting⁴

Four doctors went duck hunting one day. Included in the group were a general practice (GP) physician, a psychiatrist, a surgeon, and a pathologist. After a time, a bird came winging overhead. The first to react was the GP who raised his shotgun,

but then hesitated. "I'm not quite sure it's a duck," he said, "I think that I will have to get a second opinion." And of course by that time, the bird was long gone.

Next to spy a bird flying was the sharp-eyed psychiatrist. Shotgun shouldered, he was more certain of his intended prey's identity. "Now, I know it's a duck, but does it know it's a duck?" The fortunate bird disappeared while the fellow wrestled with this dilemma.

Finally, a third fowl sped past and this time the surgeon's weapon pointed skywards. BOOM. The surgeon lowered his smoking gun and turned nonchalantly to the pathologist beside him and said. "Go see if that was a duck, will you?"

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

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VIEWPOINT

Pride in the Profession

Audiey Kao, MD, PhD

The AMA recently presented Pride in the Profession Awards to 4 physicians who "have made extraordinary efforts to help the communities they serve by providing urgently needed health care services to indigent, under-served and at-risk patients," according to AMA President Richard F. Corlin, MD.

The awards, presented in association with Pfizer Medical Humanities Initiative, went to:

Ronald P. Bangasser, MD, Redlands, CA, for spearheading work on domestic violence awareness.

Thomas A Cornwell, MD, Carol Stream, IL, for becoming the first modern-day physician to accept the challenge of making home visits full-time.

Janelle Goetcheus, MD, Washington, DC, for founding a live-in respite care facility for homeless men in need of medical care.

Charles E. Horton, MD, Norfolk, VA, for founding an organization dedicated to providing advanced technology training to physicians and surgeons in needy areas.

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PERSONAL NARRATIVE

Through the Student's Eyes: The White Coat Ceremony

Samuel Huber

Since its inception in 1993, the white coat ceremony (WCC) has become a national phenomenon. It is now practiced at the beginning of the first year for students at more than 100 medical schools and is supported by grants from a foundation set up specifically to endorse and encourage professional development and humanism in medicine. While some literature addresses the symbolism and history of the white coat itself, only a few sources consider the meaning of the ceremony. Materials from the Arnold P. Gold Foundation and other sources that support the WCC appeal mainly to the emotion and good will felt at the event. Although these feelings are (critically) important, the ceremony's supporters ought to offer a more complete justification. Several critics have addressed various aspects of the ceremony and suggested that the WCC is misused, improper, or even unethical. These critiques have serious flaws of their own. In this article, I will examine 3 critiques of the WCC and offer an interpretation of the WCC as a contemporary medical ritual that holds a beneficial place in the professional development of a medical student.

The Gold Foundation views the WCC as an experience by which beginning students become aware of the need to balance excellence in science with compassionate patient care. A typical WCC includes the presence of family and friends, a welcome from the school administration, an inspirational message from a role model, receipt of the white coat from a physician, the swearing of an oath, and a reception with a "party atmosphere." Raanan Gillon, a physician at the University of London, describes his experience as an observer enthusiastically, and takes a significant step toward helping us understand why the WCC is important and useful. He notes the similarity between student and physician commitments, and the utility of connecting students to the idea of humanistic competence and not just scientific or technical ability at the beginning of their careers.¹

Support for the WCC is not unanimous. In response to Gillon's editorial, philosopher and bioethicist Robert Veatch presents a harsh "second opinion" of the WCC. He attacks the WCC on 2 points: the use of a Hippocratic-style oath, and the premature connection of students and faculty.²

Concerning the use of oaths, Veatch complains that students have an oath thrust upon them before they are able to decide whether they agree with it or can live up to it. He adds that there is no recourse for a student who does not agree with the oath, and that some oaths are insensitive to student beliefs. He suggests the use of

an honor code instead. He goes on to attack the use of a single oath because of the diversity of ethical traditions available today. He concludes, "an oath to practise [sic] medicine according to one particular, idiosyncratic moral code, however, is not defensible".²

Veatch considers the bonding process between students and their faculty to be detrimental to patients because it separates students from the "lay" population, making them more like priests and disconnected from the needs of lay groups. He claims that the WCC asks students to abandon their own "religious, cultural, ethnic, and national identities," and to take on the stark, empty identity of contemporary medicine. He suggests that instead, students should strengthen their personal cultural identities and then "each subscribe to the medical ethic that is appropriate for that tradition".²

Both of Veatch's arguments make the mistakes of confusing a medical oath for a complete moral code and assuming that a professional identity or responsibility must derive exclusively from an individual or personal one. In addition, Veatch misunderstands the use of oaths in this context, and neglects the importance of community among physicians.

An oath is a statement of intent, not a complete ethical stance. Clearly it is a mistake to think that all of medical ethics is only a footnote to the Hippocratic Oath.³ However, there are certain values and responsibilities in medicine that are, in principle, not very negotiable because they represent medicine's characteristic pattern of organizing values. Just as some behavior is different in a medical context than outside it, so are the responsibilities that come from being in a medical context, so it does not follow that individual values or upbringing are sufficient to reveal how to act in a medical situation.

When a student takes an oath, he or she is pledging to ethical and honorable behavior as a student, not as a physician. In the context of a WCC, the pledge is to learn within the confines these values. At graduation, one may swear to embody those values as a physician, if one desires to live that way. The examination of the professional (and shared) values of medicine (both the written codes and the demonstrated values of educators and practitioners) is part of the students' process of professional development. This is a process that should begin at the WCC.⁴ Swearing to an honor code is not enough. There is more to being a medical student than being an honest academic. Promising to cooperate and forgo cheating doesn't cover the responsibilities a student will have as a clinician-apprentice. Similarly, student-generated codes are lacking because they ask the students to decide what is important about the practice of medicine before they have ever experienced it.

Veatch's argument for a separation between students and faculty is ridiculous. The bonding between the 2 groups at the WCC is a sign of the faculty's confidence in the students, not a removal of the students' character and culture. It is a statement

that medical school is difficult, made by those who contribute to its rigor, and followed by a supportive gesture that says "I believe you can do it."

More troubling than Veatch's misinterpretation of bonding and support as isolation and detachment is his implication that students should reject any culturally based "medical ethic" that is not their own or of their choosing. This intense individualism suggests that the title of physician is empty and one of convenience to be used to legitimate whatever personal ethic or tradition students happen to bring with them to medical school. It says that you don't have to act rightly, you just have to be consistent with your personal ethic. Cultural and religious moral traditions are important. They are how many of us make decisions for ourselves. An understanding of that process is indispensable for physicians because it is often how *patients* will make decisions for themselves. It is not necessarily how decisions should be made in medicine. Medicine has an evolving characteristic pattern of balancing values that exists within a reflective equilibrium.⁵ If one's personal values conflict violently with those of the "good doctor," then it is not necessarily reasonable or defensible to ignore the professional values. A reassessment of one's career plans seems more in order. The professional development that begins with the WCC should include reflection on these possible conflicts, and a pledge to explore them ethically and honestly as a student begins the process.

As noted by medical educator Delese Wear, the WCC is not the end of professional development.⁶ In fact, it is meaningless if the institution does not embody and demonstrate the values it professes at the WCC. While she suggests getting rid of the WCC altogether, I would argue that it should stay as an important ritual in contemporary medical education. The WCC is a ritual that appropriates meaning to the white coat and helps students cross the temporal and physical boundary from wherever they were before (college, a different career) into the world of thinking and learning about the practice of medicine. It is a ritual of initiation, not one of graduation or completion. Like any good ritual, it has symbols, its own language, and an appeal to an idea larger than the individual. It begins the development of a particular type of identity: that of the medical professional. It should be a little exciting and a little terrifying because of the perceived gravity of the situation. The white coat emerges from the ritual as a symbol of professional development and humanism, and remains a tacit reminder throughout medical school. When viewed in this light, the WCC is a useful and important step in the professional development of a contemporary medical student.

An essential feature of ritual is the creation and appropriation of meaning. Philip Russell, a fourth-year student at MCP-Hanneman, fails to grasp this point in his critique of the WCC.⁸ While he is to be commended for his reflection on the components of his own medical education, his analysis is shortsighted and incorrect.

Russell complains that the WCC picks and chooses the meanings it appropriates to the white coat and therefore to medical students. I would argue that this is precisely

the point of a ritual. The creation of ritual meaning allows us to reclaim a symbol from its muddled or contradictory historical connotations, which several authors have characterized. It is true that the ceremony is disingenuous if it proposes values that do not exist elsewhere in medicine, but this is not the case with the WCC.

Further, much like Veatch, Russell mistakes a ritual of initiation for one of completion. The WCC is more like a bar mitzvah or confirmation than a medical school graduation. It says, "you have studied enough to be admitted, now go about becoming a full-fledged member." When the WCC is viewed as an initiation and first step, Russell's confused complaint of the appropriation of status trust and merit trust becomes moot.

Finally, and most disturbingly, Russell seeks to link the WCC to a perceived decline in the power (by which he means autonomy and financial status) of the medical profession. He grounds this attack in a misunderstanding of the definition and meaning of professionalism. Citing Eliot Freidson, Russell describes the "most basic tenet of any profession: [as] restricted access to a protected body of information".⁷ He calls the decline of such restricted access erosion of professional power. A closer reading of Freidson reveals that the restriction is not on the information itself, but rather on what one may do with that information.⁸ Any professional who thinks that patients are better off by knowing less about their health, or that medical power is generated solely through the withholding or restricting of information is sorely mistaken. From public health education campaigns to relationship-centered care, medicine has moved to increase patient autonomy and health through endorsing understanding of one's own health and body. Medical power comes from relationships and the fostering of healing, not the careful doling out of data.

Anthropologically, the white coat, like medicine itself (and as a symbol of medicine) has had different meanings in recent history.⁶ On this point, Russell is correct. While he objects to the ritual because it creates meaning, viewing this as somehow corrupt, I would argue instead that the appropriation of meaning is the explicit purpose of a WCC as ritual. When viewed in light of the Gold Foundation's objectives, the WCC is a step in professional development that associates some of the best qualities we would like to see in physicians with the incoming students themselves.

The WCC is a well-crafted ritual that appropriates meaning to a symbol and helps initiates move through an exciting yet daunting time in their lives. Taking an oath of initiation and being supported by the community of physicians places the student at the beginning of the development of a professional identity. The content and expression of this identity will be more greatly influenced by the student's experiences in the hidden curriculum and demonstrated values of the training institution. Nevertheless, the WCC is a useful first step in the professional development of a caring, humanistic physician, and should be continued and encouraged as a practice in medical education.

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PERSONAL NARRATIVE

Through the Caregiver's Eyes: Flowers on the Window Sill, First Day as a Hospice Volunteer

Diedre Martin

The nurse's station and hallway are empty. Within a few minutes, I hear voices, and then see a nurse and 2 other people exit one of the rooms. I recognize the nurse, Sara, who was introduced to me at orientation a few weeks ago. Luckily, she remembers me and waves a friendly hello.

After a quick but warm welcome, she introduces me to volunteers Kathy and Paul. Both have worked here for a couple of years. They spent this morning helping Sara with patient baths, and only now do they have time to catch up with other chores. Twenty minutes ago, someone from Food Services delivered a large silver cart that houses each patient's lunch and keeps them warm until a volunteer or aide has time to deliver the trays of food to the few who still eat.

Kathy and Paul begin serving the lunches. As Kathy takes out the first tray, I ask her about the soft sounds of nature I hear coming from one of the rooms. The meditative recordings of a waterfall, ocean, and the songs of birds, she explains, are from a tape. The daughter of a comatose patient hopes the sounds comfort him during those times no one from the family can be with him.

Kathy starts down the hall, carrying one of the lunch trays. Left standing alone, I hesitate, wondering if I should find Sara or wait until she looks for me. Moments later, Sara steps out from one of the rooms and beckons to me. She asks if I will spend time with an elderly patient, Mrs. Gruber, who is depressed. Sara hopes a visitor might cheer her. The woman suffers from a severe heart ailment; but, because death does not seem imminent and her pain has been brought under control, her insurance company has insisted that she leave hospice. Later today, she will be transferred to a nursing home.

Mrs. Gruber is furious over the insurance company's mandate and at the medical staff who must enforce it. No matter how often the nurse, doctor, or social worker explains why she must leave, she feels as though she is being "unjustly kicked out of hospice." Her battle lost, she has sunk into a deep depression. Unless absolutely necessary, she refuses to speak to any staff member. Sara finishes the sketch of Mrs. Gruber's problems and returns to her duties, leaving me to take on my first hospice assignment.

Mrs. Gruber sits in a lounge chair, staring down at the breakfast tray that was delivered about 7:00 this morning. On the tray several plates are filled with food. She won't allow anyone to remove the tray, claiming she is "still working on it." A large off-white plate displays two link sausages and a yellow patch of scrambled eggs that seem frozen in position. On a separate plate, toast forms a perfect stack of light-brown triangles. From the slight streaks on her glass, I think she might have sipped a little of her orange juice. The tea bag lies unopened, and by now, the small pot of water is surely at room temperature.

Shoulders curved and head bent forward so her chin almost rests on her chest, Mrs. Gruber barely looks at me when I enter the room. She continues to stare at her untouched food. I introduce myself and am gratified with a slight nod of acknowledgment. But then I stand uncomfortably in silence.

The only guest chair is inaccessible. The large chair she occupies is positioned at the foot of the bed. Wedged tightly between the chair and bed is the tray table, leaving no room for me to slip between them. Her indifference makes me reluctant to ask her to stand up so I can move the table out of the way. My only recourse is to climb over the bed, which I don't want to do unless she gives her permission. When I ask if it is okay to do so, she doesn't respond. At this point, more than anything, I just want to leave. I feel I am intruding upon her privacy, yet I wonder if there isn't some way I can help her.

I decide to make light of my situation. Adopting a joking tone, I announce my intention to climb over her bed but request that she not "snitch on me." She glances at me but says nothing. I bend down and look directly into her eyes, "Do you mind if I crawl over your bed to get to the chair?" No reaction. "Promise you won't tell on me?" With a slight nod to her head, she rewards me with a barely visible smile.

Once settled into a chair, I take notice of her appearance. Mrs. Gruber is an attractive woman in her late seventies. Her silver-gray hair forms natural, gentle waves that are brushed back from her face. Blue veins stand out in contrast to her translucent white skin. Her expression is slack, devoid of animation. I prod her with questions about her life and family, but the answers are flat even when we talk about her children and grandchildren.

"Are you married?"

She responds, simply and without emotion, "My husband died a year ago." There is a pause, "I took care of him. He was sick for a long time before he died." Then she is silent.

Believing there must be a topic that will catch her interest, I keep trying. "Are you a good cook?"

"I am an adequate cook."

"Do you cook any ethnic dishes?"

"I cook regular American food, nothing special."

I wonder when I should give up. An uninvited guest, what right have I to impose myself on her and ask these questions about her life? Am I not invading her privacy, trampling on her prerogative to be alone? I want to escape from her and the uneasy feeling that I have no business being in her room.

I try again, asking if she had worked outside the home. I learn that she was the cook in the same household where her husband worked as chauffeur. No answer does she linger over. I glean nothing about the person behind the answers—until I ask about the multitude of perfect African violets that crowd the room's window sill in pots large and small.

It is remarkable to watch Mrs. Gruber's transformation. She raises her head, looks at her velvety flowers of purple, pink, and white and then at me. Her face alters and reflects interest, and she begins to speak in longer sentences. She describes each type of violet and why it is special. Her voice becomes kind when speaking of them. It is as though she were speaking of beloved grandchildren.

"I love these flowers. People ask me for cuttings, but I never give them to anyone unless I know they will be properly cared for." Only then are they rewarded with cuttings. She encourages me to learn how to care for these "magnificent plants," and I listen intently to her enthusiastic lecture.

While talking about the flowers, she interrupts the flow of words to express how disappointed she is in everyone. Her agitation grows as she describes the injustice of the decision to put her in a nursing home. Most people, I remind her, want to leave hospice and a reassignment such as hers would be seen as an encouraging sign. But Mrs. Gruber reminds me of where she is going—a nursing home—and she dreads it. Her feelings about leaving are direct: "I would rather die than go into the nursing home."

I am reminded of my grandmother Dora. Widowed in her mid-forties, she lived with us. One of the earliest serious discussions I had with my grandmother concerned the nursing home. When she was in a bad mood, she would comment upon her fears of being sent away to it. As a little girl who loved her grandmother and saw her as an integral part of the family, I could not understand the fears she expressed. Besides, I saw my grandmother as young and healthy. I had a vague understanding that the nursing home was for old and sick people. It didn't matter what I thought. My grandmother feared it just like Mrs. Gruber does now.

Thoughts of my grandmother renew my desire to help Mrs. Gruber, but she shows no interest in my attempts and finds nothing compelling in my arguments. Leaving hospice for the nursing home is worse than a death sentence to her, and she views

the continuation of her life with indifference. The joy she exhibited while speaking of her violets is gone. If she ever felt enthusiasm for life, it had been spent long ago.

I offer to help her back to bed, but she refuses. I climb back over her bed and leave, carrying the breakfast tray cluttered with uneaten food.

As I drive home late in the afternoon, I wonder if this is the type of community service I want to do. I am afraid what I see in hospice will depress me and affect my mood at home. I decide I will commit to the work for 6 months, and then reevaluate my decision. One thing I am sure of: No matter how briefly I choose to do this type of work, it will be challenging.

Death plucks my ear and says,
"Live - I am coming."
(Virgil, 70-19 B.C.)

Diedre Martin lives with her two daughters in Milwaukee where she writes and works with members of a documentary film company.

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