EDITORIAL

Bringing Professionalism to the Bedside

In February 2002, the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine published in *Annals of Internal Medicine* and *The Lancet* a document titled the Charter on Medical Professionalism (1). The Charter provides an ethical, educational, and practical framework to guide physicians in the practice of medicine and in their relationships with patients, colleagues, and society. The practical application of these principles is the last joist in this framework, and it is the most difficult to convey in a document such as a Charter. Most physicians would find the Charter doctrine sound, but the real world of medicine often presents obstacles to the application of the individual Charter principles and associated professional commitments.

In an effort to bring professionalism down to earth and closer to the bedside, *Annals* and *The Lancet* will publish a special series in collaboration with the American Board of Internal Medicine. The series will include 6 essays, each with an accompanying commentary on how the essays illustrate the application of the principles in the Charter. We have selected the essays from submissions to 2 popular features in *Annals*, On Being a Doctor and On Being a Patient. These essays portray the emotional, spiritual, and humanistic faces of medicine. In doing so, they often powerfully portray how physicians succeed or fail to apply the principles of professionalism to the messy real world of medicine. The first essay, "Lessons from the Third Year" (2), and commentary (3) appear in this issue and illustrate a medical student's struggle with reconciling the Charter principles of maximizing patient welfare and assuring social justice in the distribution of scarce resources.

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Professionalism and the Medical Student

According to the Charter on Professionalism (1), 3 principles lie at the core of professionalism in medicine. The first principle, primacy of patient welfare, stresses altruistic dedication to the well-being of the individual patient. The second principle, patient autonomy, urges physicians to facilitate patient involvement in treatment decisions. The third core principle, social justice, calls upon physicians to work actively toward equitable societal distribution of health care resources.

In the poignant essay "A Lesson from the Third Year" (2), which appears in this issue, a medical student caring for an elderly Chinese immigrant encounters each of the 3 core principles of professionalism. The problems the student faces in the care of this patient (cultural isolation, lack of English proficiency, undocumented immigrant status, homelessness, poverty, and lack of medical insurance) are largely social problems. However, these social issues form the context in which physicians deliver health care, and they provide opportunities to apply the principles of professionalism. The story of this medical student and his patient underscores that medical school presents a unique opportunity to nurture the core principles of professionalism in the physicians of tomorrow.

For the medical student in this essay, primacy of patient welfare was a driving force. The student offered the only things he had as a student—"my time, my ear, and my voice"—for the benefit of his patient. The principle of patient autonomy—empowering informed treatment decisions—presented special challenges in this patient's care, primarily because of language and cultural barriers. The student must have wondered whether this 70-year-old man would have elected dialysis, kidney transplantation, or nursing home placement if he had fully understood his predicament and was able to make decisions about his care. However, the student's most difficult struggle is with social justice, a principle that urges physicians to work actively to eliminate discrimination in health care and to assure fair distribution of finite resources. The student's patient, an uninsured illegal immigrant, raises thorny questions about just allocation. In our society, health professionals are faced

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with a seeming paradoxical choice between the primacy of patient welfare, which puts the interests of the individual patient first, and the fair distribution of limited resources, which urges respect for societal resource limitations. This apparent conflict can be overcome through a commitment of the medical profession to professionalism. The principle of social justice not only informs decisions made within the health care system but also informs those made in caring for an individual patient. Professionalism includes an imperative to remove social and cultural barriers to high-quality cost-effective health care, especially for people who are disadvantaged and marginalized. The principles of professionalism can shape the intellectual framework that physicians bring to their clinical experiences, foster greater understanding of their responsibilities, and teach them to offer and demand moral and ethical evidence and justification for their clinical behavior.

Medical school presents a unique opportunity to establish a foundation for professionalism that students can build upon throughout their careers. Even though development of professionalism has become a focus of medical school and postgraduate physician education, current teaching too often fails to take advantage of the actual situations that students encounter in the wards and clinics. Consequently, we miss powerful opportunities to teach students how to apply the principles of professionalism in the social and cultural context of daily practice.

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ON BEING A DOCTOR

A Lesson from the Third Year

During my medicine clerkship, I had the privilege of caring for a man whose case brought up many questions and dilemmas in my mind. Mr. L. was a 70-year-old Chinese man who spoke only Cantonese, but in a dialect that most translators found incomprehensible. He apparently had no family and was in this country illegally. He lived with a group of other Chinese people, all of whom worked for a restaurant and lived with the owners. It was questionable whether Mr. L. had ever seen a western doctor before. He presented to the emergency department with severe abdominal pain, having not voided in some time.

The doctors determined that Mr. L. had a urinary obstruction secondary to benign prostatic hypertrophy. They relieved this problem through catheterization, but Mr. L.'s kidneys functioned so poorly that the doctors thought Mr. L. had some form of chronic renal failure as well. A doctor performed a renal biopsy that showed severe glomerulosclerosis, and renal failure was imminent. Dialysis was begun promptly. After learning of his condition, the owners of the restaurant declined to assume care for the man. They refused to allow him to continue residing with the other workers or to provide transportation. Since no other family or friends could be found to provide care, Mr. L. sat in the hospital for weeks and then months awaiting an indefinite placement to a nursing facility that would arrange for his dialysis.

I joined in this story several days after the patient's initial admission. The case was confusing, not so much from a medical standpoint but from the perspective of preserving the patient's dignity and quality of life.

The most obvious barriers to care in this case were language and culture. The hospital had 24-hour access to a telephone translator, but I realized quickly that this service was not being used. It seemed like most of the doctors and nurses were either ignoring Mr. L., perhaps uncomfortable with the language barrier, or doing quick exams in which the subjective response was inferred. The typical progress note for Mr. L. was something along the lines of "Patient Chinese speaking. No c/o . . . ." Interestingly, Mr. L. was receiving no medicine for pain. A physician had written an order for as-needed pain medicine, but Mr. L. couldn't communicate his pain. I found no indication that anyone had made the effort to ask. When I dialed up the translator on my first day, Mr. L. reported that he was extremely uncomfortable.

Second, I realized that even with translation, Mr. L.'s comprehension and insight were extremely poor. I spent many hours explaining things and obtaining consents. Mr. L. never had any questions. When I stopped to ask, "Do

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you understand? Do you have questions? What do you think of this?" Mr. L. always gave one response to the translator. "If Doctor thinks this is best . . . ." Eventually, it dawned on me that Mr. L. just wasn't getting it. Either he was in denial, or he never really understood. As the picture became more dire, he began asking me questions without any sense of irony: "How many more times must I go to dialysis?" "When can I go back to live with my friends?" and "Will I leave today?" My heart broke as I realized I would have to be the one to disappoint him.

Throughout the whole ordeal, I think Mr. L.'s biggest complaint was about his Foley catheter. He *hated* it and could never understand why he needed it. At one point, he tried to pull it out. I don't think Mr. L. ever knew what a prostate, kidneys, or a nursing home were.

Finally, I saw Mr. L.'s ultimate disposition as a tragedy that I continue to question. At the time, no one seemed comfortable addressing my questions about the patient's placement and the possibility of a transplant. The reactions I got ranged from shared concern to indifference to anger. *Don't you understand that the hospital is eating all the cost for this guy? He's lucky we don't put him on a plane back to China.* This was what some seemed to imply.

What a sad and lonely outcome: to be relegated to a state nursing facility where he could speak to no one and had limited understanding of the reason for his placement. I could picture it as a prison of both the mind and the body—and in our zeal to be doctors, we handed Mr. L that sentence.

What was our responsibility to this man who lived in this country illegally and had no ability to pay? Should he be eligible for a transplant? Should we blame the other workers and the restaurant owner for not taking him back? They had used his labor while he was healthy, but turned their backs on him when he became sick. Was all of this "care" even what the patient desired? If he truly understood the implications for his future life, perhaps he would not have always assented to the "Doctor."

My role in this story was to offer the only things I had as a student—my time, my ear, and my voice. I took time every day to use the translator to ask Mr. L. how he was, to tell him what to expect, to search for his questions, and to try to understand his story. I picked up some Cantonese—"jo san" was our morning greeting. I became associated with Mr. L. in the minds of the staff; I had them page me when he had the occasional visitor. I would hurry to his room, hoping in vain that this person could explain things to him more clearly or give me some special insight. I brought up Mr. L. during our inevitably speedy rounds, just to keep him from being summarized by the single word—"placement."

When I completed my medicine clerkship, Mr. L. had been in the hospital for over 8 weeks and continued to await placement. I said goodbye and told him I would no longer be taking care of him. He thanked me, and I believe he looked confused.

I don't know where Mr. L. is now, or how he is doing. I still think of him and wonder if we did right by him. I wonder if I did enough. I hope he has many visitors, and that he is greeted with "jo san" in the morning.

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