Editorial

An epiphany—requisite for all physicians

> Being a professional is doing the things you love to do on the days you don't feel like doing them.
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> —Julius Erving, reported by David Halberstam

A short vignette came to *The Pharos* from third-year medical student Neelam Vashi at Northwestern University, describing her contact with a fourteen-month-old little girl whose weight and length were at the fiftieth percentile for a two-month-old child, a little girl "who never wondered why." She describes the girl:

> Her skin, an ochre green like the dull yellow-green of unripe olives, was always held taut against the rigidity of her facial bones. Her big, brown eyes staring, always staring. But, oddly, those same big brown eyes never shed a tear. She never wondered why.
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> She never wondered why she spent day and night in the hospital. Why all her meals were taken through a G-tube. Why, in the midst of life, she was the owner to the labels of failure to thrive and developmental delay.
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> I have continued to wonder why. Why little girls who have done no harm are forced to live in pain. Why as the world keeps moving forward, day by day, some are left behind with failure to thrive.
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> I wonder how a little girl who had no voice was able to put thoughts and questions in my mind, who was able to touch my soul.

Ms. Vashi's soul was touched. The invisible walls that separate us from each other were broken down. It is very likely that from that moment on this young woman, about to be a physician, will readily and promptly form deep associations with, and commitment to, her patients.

I suggest that every young physician must have such an epiphany—a moment of sudden revelation or insight—before he or she is truly able to serve the suffering. A young physician's epiphany, the time spent with a single patient that makes him or her forever committed to the thoughtful, long-term care of that individual patient and all others, is a major ingredient of professionalism in medicine. Probably most of us who have been out in the clinics and hospitals for more than just a few years experienced our epiphanies when alone with a patient, or a patient and relatives, late at night, when few others were on the wards. Mine came while trying to save a young father who came to the emergency room at 8:00 PM in a coma and was found to have staphylococcal meningitis. Intrathecal antibiotics, even intrathecal DNAase, didn't work. He died just before dawn. My walls were trampled down then and forever. A fellow resident had his similar epiphany forty-three years ago as he titrated administration of intravenous EDTA all night long to a patient with severe digitalis toxicity. His patient lived, although no one would say that giving the chelator was important for his survival.

In contrast to these experiences, the daughter of a colleague, several months into an R-1 year in 2006, stayed on well beyond her prescribed hours to be with a very sick patient. Rather than being commended for her caring, however, she was dressed-down and scolded by a chief resident for violating the week's eighty-hour maximum.

Turn now to the Letters to the Editor to read the letters from Drs. William Rogoway, Lawrence Faltz, and Kelley Skeff and Lawrence Smith on the subject of duty-hours standards. Rogoway wonders, "Do patients and the educational process benefit from a major focus on whether one has worked too many hours? It seems clear that patients benefit from a continuous relationship with one physician. The more trade-offs there are, the less intimate that connection becomes." While not mentioning a particular epiphany during his recollections of long hours in training, Faltz notes that, while working those long hours, "One was transformed, marked by the experience with a different perspective on one's role in society and an intrinsic understanding of what it means to be a professional." Recognizing that many program directors also have concerns about the effectiveness of these time-on-service rules, Skeff and Smith nevertheless point out that any redesign of residencies cannot focus on hours requirements because "these are sensible from both educational and patient care points of view." But they do point out that "by emphasizing the integration of patient care and education, we have the opportunity to again foster the commitment of each individual trainee to his or her patient."

From another direction, numerous educators are designing and implementing the formal teaching of ethics, professionalism and humanism to medical students. David T. Stern and Maxine Papadakis,[1] two prominent leaders in this movement, have set out mechanisms for setting expectations for students, the various educational experiences—including formal curriculi, role models, community-based education, and patient-doctor courses—that should be available for students, and the ways to evaluate outcomes of these programs. As they point out, "Physicians are asked to deliver professional care in a complex and ever-evolving health care system, and medical educators have a critical role to play in maintaining and enhancing professionalism." We must hope that the formal curriculum in these subsets of professionalism will help lower the thresholds for students and residents to experience the epiphanies that will forever change them from graduate students who have mastered the basic elements of medical science and clinical diagnosis into true healers.

References

1. Stern DT, Papadakis M. The developing physician—becoming a professional. N Engl J Med 2006; 355: 1794–99.

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