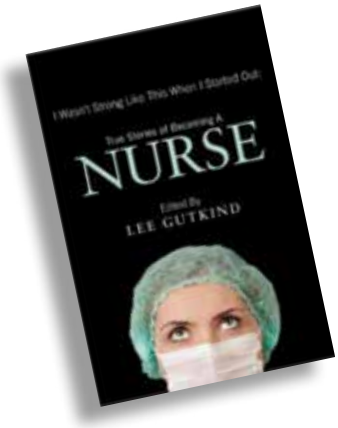
Reviews and reflections

David A. Bennahum, MD, and Jack Coulehan, MD, Book Review Editors

The book review editors request that books for potential review be approved by the editors before the reviews are written. Reader interest and space are always considerations in this section and unsolicited reviews may be rejected. Contact Dr. Bennahum at dbennahum@salud.unm.edu and Dr. Coulehan at john.coulehan@stonybrookmedicine.edu.



I Wasn't Strong Like This When I Started Out: True Stories of Becoming a Nurse

Lee Gutkind, editor
Pittsburgh, In Fact Books, 2013

Reviewed by Judy Schaefer, RN, MA

Let me say this before I say anything else: I LOVE these stories. Yet, had I not been asked to write this review, I would have unwittingly left this book to gather dust on the shelf. Why? The cover has four lovely blurbs written by doctors. The early praise for this book of creative nonfiction by nurses came from a total of nine doctors. All nice and knowledgeable people, surely, but what do nursing leaders think of this book?

I can't help but chuckle as the cover blurbs reflect the trite and out-of-fashion tradition of physician approval. The cover of the book suggests that nurses, the nursing profession, still seeks primarily—*primarily*—the praise of physicians.

Ironically this collection illustrates nursing autonomy. We can remain seated when doctors walk into the room and we "implement prescriptions"; we don't take orders. Some of us with advanced degrees write prescriptions. We nurses "consult" with each other and with our multidisciplined colleagues. We provide peer review and peer support. A nurse is not a handmaiden to the physician but works with the doctor as colleague in the best interest of the patient.

Perhaps the book is intended for doctors? Every doctor should indeed read this book. The narratives are such a good source of information for doctors, the public, and nurses, and especially nursing and medical students. What would Flo* say?

The narratives in this book are bold, funny, scary, and true to the bone. Twenty-one nurses tell compelling stories of their training and subsequent growth in the nursing profession. Their stories can be the basis for learning as well as for entertainment. I wish I could have read and discussed these stories when I was a nursing student. They are powerful.

As the nurses in this collection describe, nurses make decisions on the spot and on the run, without recourse to contemplation at a desk. A family member once brought this to my attention when she asked, "Where is the nurse's desk?" I had never thought of it before. These ward warriors make life-and-death decisions on the go, in soft shoes, with grace and good humor—as these stories attest. There may be a break room or cubicle where coffee is dosed out in between patients and family, attendings, interns, and residents, medical and nursing students, but nope—nope—no desk for retreat. Nurses learn to turn on a dime in the fishbowls of their wards, trailing a computer; or in the patient's home trailing a phone. Graceful and elegant. Swift and bold.

All of these stories have both strong "telling" voices and strong interior, self-deprecating, voices loaded with good humor. In fact, humor is one of the strongest tools for these nurses. I laughed reading Eddie Lueken's "Hitting the Bone." Demonstrating the good student's desire to learn and experience hands-on skills, she writes, "I was paying the college to teach me how to keep people alive; I already possessed the skills to let someone die."[p27] The interior dialogue of this essay is priceless. Oh, I wish I would have read this one as a student.

I wanted to cry when I read Kimberly A. Condon's "Approaching Death." In the first paragraph she writes, "There is a terrifying, soul-piercing scream that a mother makes when she loses a child. This scream is so universal that everyone, in every corner of the emergency department, knows what has just happened when they hear it."[p247]

I sympathized and felt a chill when I read Thomas Schwarz's "The Haunting." While a story of the loss of innocence, it is also a soul-searching story of scarring and redemption. He writes, about himself and his patients, that not all injuries can be seen and judged with the human eye or reasoned with the human mind. "Nor do all illnesses have scientific, rational roots. Some surround the heart like barbed wire, never admitting peace or happiness, never allowing the release of residual, unspoken, or misplaced guilt."[p41] This is a superb story for both new and experienced nurses.

I wanted to jump and shout when I read Tilda Shalof's "I See You." Her superb writing inspires the title of the collection. She writes, "Most of all, you need moral courage because nursing is about the pursuit of justice. It requires you stand up to bullies, to do things that are right but difficult, and to speak

* Florence Nightingale.

your mind even when you are afraid. I wasn't strong like this when I started out. Nursing made me strong."[p150] Does Shalof remind us that nurses are like hired-guns and are certainly paid observers? I laughed and I cheered as I read her description of the nurse as angel, "In addition to holding the patient's hand, that nurse had analyzed her twelve-lead electrocardiogram and monitored her for arrhythmias. She had drawn serum troponin levels and ensured that electrolyte levels were normalized. She had given information, oxygenation, anticoagulation, and pain relief."[p151] Not just another angel! These angels have strong wings.

The implications and challenges of diverse cultures are inherently addressed in all of these narratives and specifically addressed in "Healing Wang Jie's Bottom" by L. Darby-Zhao, "Docking in Togo" by Jennifer Binger, as told to Ann Swindell, "Listening and Other Lifesaving Measures" by Karla Theilen, and "Messiah, Not Otherwise Specified" by Janet Gool. These are superb essays for discussion by students of nursing and medicine who are interested in global as well as domestic health care pursuits.

Pamela Baker's "Individually Identifiable" touches on the need for stories in spite of the HIPAA climate. She addresses issues of policy and procedure that could be the ground work for policy research. And importantly she touches on the reasons nurses do not write. What an essay to facilitate discussion for nurses in their English requirement courses!

The narratives could be read one at a time or in one setting from front to back. Each one stands alone. Read them as you will. Now having said this, I thought the book ended poignantly with "The Nurses Whispered" by Patricia A. Nugent and "Becoming" by Lori Mulvihill. "The Nurses Whispered" is subtle truth telling and "Becoming" is a loving summary. They bring the book to a satisfying closure with a respectful and knowing salute to the nursing profession. Well done!

And—one more thing—and write this on your cover: Flo would like this book! No, that's wrong. Flo would LOVE this book!

Judy Schaefer, RN, MA, edited the first biographical/autobiographical work of English speaking nurse-poets, *The Poetry of Nursing: Poems and Commentaries of Leading Nurse-Poets* (The Kent State University Press, 2006), and co-edited the first international anthology of creative writing by nurses, *Between the Heartbeats* (University of Iowa Press, 1995). Her address is:

4423 Carrington Court
Harrisburg, Pennsylvania 17112
E-mail: jschaefer@mindspring.com

Forgive and Remember: Managing Medical Failure

Charles L. Bosk
Chicago, University of Chicago Press, 2003

Reviewed by Jack Coulehan, MD

In the late 1970s, sociologist Charles Bosk spent eighteen months as a participant-observer in the surgical residency program at a major West Coast teaching hospital. His report, *Forgive and Remember: Managing Medical Failure*, which became a classic of medical sociology, investigated power relationships and decision-making in academic surgery. Bosk described four types of error and the consequences of each for surgical residents. In technical errors the surgeon performs "his task conscientiously, but his skills fall short of what the task requires."[p37] Errors of judgment occur "when an incorrect strategy of treatment is chosen."[p45] When a resident makes a technical or judgmental mistake in patient care, his superiors' response is generally supportive, despite scrutiny at the Morbidity and Mortality Conference, and the resident is forgiven, as long as his mistakes are infrequent, and he learns from them. Hence, the book's title, *Forgive and Remember*.

The third type, normative error, occurs when a surgeon fails "to discharge his role obligations conscientiously."[p51] In other words, the surgeon neglects his duty to a patient or to his colleagues on the surgical team because of laziness, inattention, lack of respect, or irresponsibility. Quasi-normative errors represent a failure to discharge an obligation specific to a given hospital or surgical service, i.e., a regimen the Chief insists upon, although other approaches might be equally valid. Normative and quasi-normative errors are considered moral failings, rather than evidence of insufficient skill. Accordingly, they evoke a more negative response from attending surgeons. A resident guilty of normative error can expect dire consequences, e.g., failure to advance, or even immediate dismissal.

This second edition of *Forgive and Remember* deserves our attention because it sheds new light on Professor Bosk's study. He now confesses to having made his own errors of judgment in writing the original book. In a remarkable Appendix entitled, "An ethnographer's apology, a bioethicist's lament—The surgeon and the sociologist revisited," Bosk describes two omissions that he once considered trivial, but he now realizes were important.

The first omission relates to his discussion of the process by which residents were chosen for advancement to the next level, or dropped from the

program. At the promotion meeting, only one resident failed to make the grade. Every one of the senior surgeons considered that person guilty of normative errors, i.e., unprofessional behavior. In fact, attendings applied words like "sick" and "crazy" to the resident. Following standard practice, Bosk preserved the confidentiality of his subjects by altering names and other distinguishing features—including gender. Thus, the failed resident, always referred to as "he" in the book, was actually a woman; in fact, she was the only female resident.

There were no precedents for a female surgical resident in that program. While the male sociologist blended in with the surgical "gang," the female resident never did. She remained an outsider. How much did this alienation affect her performance? How much did her attendings' bias affect their evaluations? Was she considered "sick" or "crazy" simply because she aspired to become a surgeon? Whatever the answers, there can be no question that her gender was an important datum omitted in the original edition.

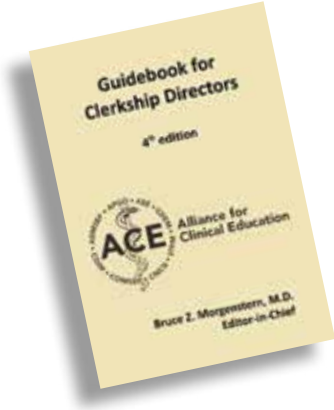
The second omission Bosk reveals is "the hectoring, often abusive behavior of senior surgeons."[p223] He originally chose not to tell his readers that "verbal harassment was a rather routine event for all residents,"[p223] at least in part because he wanted his work "to read differently than other sociological accounts of this time which seemed to engage routinely and somewhat unreflectively in doctor-bashing."[p228] The author believed that if he gave a full account of this harassment, it would distract the reader from his major theme, an analysis of decision making in the strict, authoritarian social system of a surgical residency. He didn't want to be just another doctor-basher. In the new Appendix, he describes a typical example of harassment. In the operating room, a senior surgeon verbally "trashes" both Bosk and a resident, makes derogatory comments about "slopes, gooks, and dinks" to an Asian anesthesiologist, and asks an African-American scrub nurse, "Do you know how many times I had to practice this operation on blacks before they let me do it on whites?"[pp226–27] Tellingly, the author has to reconstruct this scene from memory because he failed to include it as important in his field notes.

Why did the author choose after all these years to reveal his omissions? He considers several reasons, ranging from personal catharsis to demonstrating the difficulty of using supposedly detached and objective ethnographic data to draw inferences about professional morality. It is obvious to today's reader that the female resident's failure cannot possibly be understood in isolation from gender discrimination and sexual harassment. It is also obvious that any resident's response to intimidation and humiliation by superiors must have influenced how normative and quasi-normative errors were perceived and evaluated.

This raises another question: Why recommend a decades old ethnographic study recently revealed as flawed from the outset? In my opinion this new edition of *Forgive and Remember* is doubly relevant. First, it remains a richly detailed investigation of surgical training that still applies in many ways to clinical education today. This is especially true with regard to the classification of error and the relative valuation of technical and moral competence. Second, the author's revelations provide the reader with an altered lens through which to view his original ethnographic narrative. The temptation to delete messy details that don't "fit" with a preferred diagnosis is always present in medicine. The new *Forgive and Remember* is a "retrospect-o-scope" that teaches how important such details can sometimes be. It also shows how much the mores of clinical education have changed in the last thirty years. Unfortunately, gender discrimination and trainee harassment still occur, although now considered aberrant, rather than routine.

Dr. Coulehan is a book review editor for *The Pharos* and a member of its editorial board. His address is:

Center for Medical Humanities, Compassionate Care, and Bioethics
Stony Brook University
Stony Brook, New York 11794-8335
E-mail: john.coulehan@stonybrookmedicine.edu



Guidebook for Clerkship Directors, 4th edition

Alliance for Clinical Education, Bruce Z. Morgenstern, editor
Gegensatz Press, 2013

Reviewed by Deepti Rao, MD (ΑΩΑ, University of New Mexico, 2013)

As clerkship directors, we love teaching and working with medical students. To that end, we tend to be a busy group of people with a number of academic projects. We also generally realize the limits of our knowledge and seek counsel when necessary. So finding a practical educational reference that is well written by notable medical educators is invaluable. I found the Alliance for Clinical Education's *Guidebook for Clerkship Directors* to be such a book.

I have to admit, when I was handed the Alliance for Clinical Education's *Guidebook for Clerkship Directors* several months ago, I planned to read the tome from cover to cover. Indeed, I started out that way, reading the initial information packed chapters with gusto. However, soon life

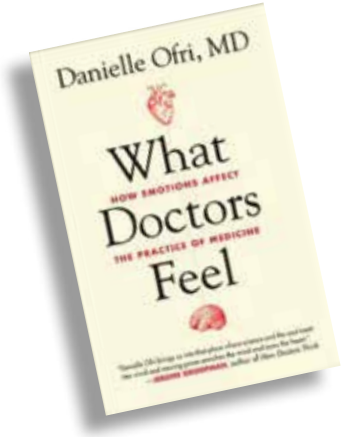
interrupted and I lost my way in that noble pursuit. Instead I began to read single chapters as questions came up for which I needed answers. And to my surprise, I found that in following my own academic pursuits, over the course of several months, I had the chance to read most of the chapters in this book. For instance, I am working on a clinical reasoning elective for fourth-year medical students, so I read the chapters on clinical reasoning and working with students who had experienced difficulties. I am in the process of revising a behavior-based PRIME grading form that I helped develop, so I read a very helpful chapter on evaluation of students (authored among others by Louis Pangaro). I am currently working on a simulation-based training for clinical procedures, so I read the chapter on simulation in medical student education. The book mirrored the information I needed to gain not just as a clerkship director but also as a medical student educator.

With respect to the book itself, I found the chapters very thorough, well organized, and easy to understand. I presented a few of the chapters above but there are several other topics including but not limited to chapters on the management of a clerkship, the clerkship orientation, longitudinal clerkships, and career development. I found the chapters presented new knowledge that often gave me some new insight or helped me structure the thoughts I had about the subject. For instance, the chapter on clinical reasoning had a very thorough and organized summary table outlining teaching strategies and tools. Also the chapters were organized so that if I wished to read a good review of a subject I could, or if I wanted to skip to a very specific topic I could do that as well.

As a busy clinician with a family it is definitely hard to find time to research and read on every topic. This book has a wealth of information in a very accessible format. As stated at the end of the first chapter, "This guidebook is intended to be a reasonably complete manual for clerkship directors as well as other members of the medical student teaching team." That makes it very valuable not only for clerkship directors, but also for any clinician who teaches students of medicine and the health sciences. I recommend the book as a truly unique and helpful guide.

Dr. Rao is an assistant professor of Internal Medicine at the University of New Mexico Health Sciences Center. Her address is:

University of New Mexico School of Medicine
MSC10 5550
Albuquerque, New Mexico 87131
E-mail: drao@salud.unm.edu



What Doctors Feel: How Emotions Affect the Practice of Medicine

Danielle Ofri, MD
Boston, Beacon Press, 2013

Reviewed by Johanna Shapiro, PhD

Emotions in medicine are both a neglected and problematic subject. As internist and author Danielle Ofri observes in her new book *What Doctors Feel*, the model of detached concern is still prevalent in clinical practice and in training. As she writes, "the often unspoken (and sometimes spoken) message in the real-life trenches of medical training is that doctors shouldn't get too emotionally involved with their patients."[p4] But what does this really mean? Medical education rarely addresses the emotions of learners, although research has documented an intense panoply of positive and negative emotions. Even outstanding physician role models rarely discuss their feelings, leaving medical students to attempt to deduce appropriately professional emotional responses from indirect verbal, nonverbal, and behavioral cues. The medical literature as a whole is surprisingly silent on this topic.

Thankfully, Ofri has stepped forward to tackle this sensitive issue. Through a series of examples derived from her own clinical encounters and those of other physicians, as well as regular citation of relevant literature, she makes the argument (using a metaphor borrowed from the neuroscientist Antonio Damasio) that the physicians' feelings are the "underlying bass line"[p3] exerting a profound effect on their actions regarding patients. In a bold and forward-looking move, Ofri calls for careful attention to, understanding of, and skill to work with personal emotions in the interests of patient well-being. Although she rarely uses this term, in effect she suggests that physicians need to develop emotional intelligence.

Following in the footsteps of Jodi Halpern, Jack Coulehan, William Branch, and countless other physician-scholars, Ofri reminds us of the key role of empathy as the gateway to managing one's emotional reactions and achieving the goal of compassionate care. She recognizes that it is easiest to feel empathy when the patients' suffering "makes sense,"[p10] and much harder when it does not. Yet empathy (which of course is not the same as enabling or indulging the patient's every claim) is essential in all clinical encounters, not simply those involving likeable and grateful patients. Yet how to cultivate empathy under challenging, time-pressured circumstances is rarely included in the curriculum. Reflecting on her own training (mostly by older white male physicians)

she identifies the quality of respectful curiosity, "the . . . act of taking a patient and her story seriously,"[p54] as going a long way toward yielding positive doctor-patient relationships.

The chapter "Can We Build a Better Doctor" skillfully dissects the multiple pressures on medical students to de-identify with the patient and instead cathect to the residents and medical team. This often means prioritizing efficiency and productivity over compassion, laughing at or making fun of the patient, and not protesting the use of derogatory terms such as "gomer" (an elderly, demented nursing home patient) or a racially charged term such as "status Hispanicus" to refer to a vocal patient in labor. This and similar chapters on medical malpractice point to some of the systemic underpinnings of physician disillusionment and resultant "bad behavior," and suggest that solutions focused only on the individual level are doomed to failure.

Ofri does the medical community a favor by naming some of the most difficult emotions that physicians experience, starting with fear. There are small fears (looking or actually being incompetent in a given situation) and large fears (is this really the right profession for me?) in medicine, all culminating in the oppressive fear of doing irreparable harm, or even killing a patient. Ofri points out the paralyzing nature of some fears, and consequent suboptimal (or terrible) care to patients, as well as great suffering to the physician. This is a heavy burden to bear, but it cannot be addressed by silence. Ofri recommends stress management, support groups, and mindfulness meditation, all of which have been demonstrated to improve physician well-being. But until the culture of medicine shifts so that it can acknowledge these fears, medical students and their role models will have to struggle along in relative isolation.

Another emotion to which Ofri deservedly gives much attention is loss and grief. Medical students at an early age and physicians throughout the course of their career are surrounded by chronic suffering, progressive incapacity, and death. How—and when!—do physicians mourn these losses? How—and when!—do they appropriately give vent to their grief? All too often, as Ofri and others have observed, grief is simply buried. The team moves on to the next patient and there seems to be no time and no inclination to mourn. Ofri points out that sadness, like fear, is unavoidable, and further, that neither emotion is without value (the alertness that results from a certain level of anxiety can keep the physician on her toes; grieving for a patient can bring some measure of peace to the physician), but the key is to learn how to navigate these emotions so that they do not destroy the physician, but rather serve the larger goals of patient (and physician) well-being.

Ofri also discusses shame, and its disabling properties. Whether her distinction between guilt (about a specific behavior) and shame (a more global experience) is accurate, her larger point is that the toxic blaming and shaming that still occurs in medical school and residency training has persistent negative effects that paradoxically make it more difficult to accept responsibility for mistakes and apologize to patients. The tendency to hide and cover-up incidents perceived to be shameful, and the resultant quest for perfectionism, is both unrealistic and detrimental to good patient care.

Burn-out, stress, and disillusionment with the profession of medicine are also considered in *What Doctors Feel*. Ofri pinpoints many causes, from paperwork, time pressures, financial demands, family strains. None of these insights is new—much research and anecdotal reports already exist supporting the deleterious consequences of these conflicts. But Ofri brings these experiences to life. She is particularly eloquent on the emotional toll malpractice suits extract, citing evidence that concludes that, whether the physician is found liable or not, the emotional reverberation of anguish and self-doubt is lengthy and profound. In her words, they are "soul-corroding events,"[p190] often because the physician had a strong emotional connection with the patient.

What Doctors Feel is written in accessible, personal style, easily absorbed by lay persons, medical students, and physicians alike. One of the most touching aspects of the book is the narrative of Julia, a longtime patient and undocumented immigrant with two children about whom Ofri wrote in *Lost in Translation*. Charting the ups and downs of Julia's progressively worsening struggle with genetically induced CHF while she is in her thirties and forties is a moving example of relationship-centered care. Ofri does not shy away from documenting the joys and heartbreak she experiences in caring for Julia. She does not expect that she—or other physicians—should feel such emotional connection with all patients. But she does fearlessly excavate all that it can mean to step within the orbit of a patient's suffering, yet not be pulled so closely that she implodes. The result is a portrait of the doctor we would all long to have as we embark on our final journey.

What Doctors Feel takes a crucial step into the murky waters of emotion, long a taboo subject among both academicians and practitioners. It points the way toward systematic research, teaching, and clinical practice that acknowledges the humanity of the physician, as well as of the patient, in the service of better patient care.

Dr. Shapiro is Director of the Program in Medical Humanities & Arts and Professor of Family Medicine at the University of California, Irvine, School of Medicine. Her address is:

University of California, Irvine
Rm 835, Bldg 200, Rt 81
101 The City Drive South
Mail Code 2975
Orange, California 92868
E-mail: jfshapir@uci.edu