Doctor/Patient Relationships
December 8, 2007
3:00 p.m.
The Philoctetes Center

Levy: **Francis Levy**
Nersessian: **Edward Nersessian**
Doerries: **Bryan Doerries**
Jacobs: **Jonathan Jacobs**
Konopasek: **Lyuba Konopasek (moderator)**
Michels: **Robert Michels**
Pangaro: **Louis Pangaro**

A: **Speaker from audience**

Levy: I just wanted to say that I really was very honored to have the group of actors that did the performance of *Philoctetes*. It was really an amazing rendition of the play. That obviously was the basis for the naming of the center and it's the subject of our discussion here today: the play influencing that discussion.

I'm now very honored to introduce Lyuba Konopasek—is that the correct pronunciation?—Associate Professor of Pediatrics and Director of Pediatric Undergraduate Medical Education at Weill Cornell Medical College, and with whom I also attended a previous Philoctetes panel and session. I think you have a little bit of a surprise idea that you're going to tell us about in a couple of minutes. But just to continue—her particular interest is in medical interviewing and the physician-patient relationship and she is developing a longitudinal four-year communication skills curriculum at Weill Cornell. She is also interested in the integration of the arts and humanities into medical education and leads a collaboration between Cornell and the Frick Collection to increase students' clinical observational skills through the study of portraits.

Now Lyuba is going to moderate today's panel and introduce our other distinguished panelists. Thank you.

Konopasek: Let me introduce you to Jonathan Jacobs, who is Executive Director of the Center for Special Studies at New York Presbyterian Hospital, Cornell campus. He's a Professor of Clinical Medicine at Cornell. He hails from Yale University School of Medicine, where he went to school and completed his residency training in internal medicine at New York Hospital. He subsequently trained in the subspecialty of infectious diseases at the same institution. He has been a clinician, administrator, and educator for the past 21 years, with a particular interest in HIV. Welcome.

The next person I'd like to introduce to you is Dr. Bob Michels, who is the Walsh McDermott University Professor of Medicine and Psychiatry at Weill Medical College and Training and Supervising Analyst at the Columbia University Center for Psychoanalytic Training and Research.

Bryan Doerries is a New York based writer and director. Over the past decade he has directed many of his own translations of Greek and Roman plays at theaters and universities across the country. Recent theatrical projects include *The Bacchae* of Euripides; Sophocles' *Ajax*, *Antigone*, *Women of Trachis*, *Bloodhounds*, and *Philoctetes*; Seneca's *Phaedra* and *Octavia*; and Virgil's *Aeneid, Book IV*. He has a B.A. in classics from Kenyon College and an M.F.A. in Directing from the University of California, Irvine.

And finally, Dr. Louis Pangaro, who is Professor and Vice-Chairman of Educational Programs in the Department of Medicine at the Uniformed Services University in Bethesda, Maryland.

We were thinking how we were going to move the session from downstairs and the reading that you just heard up here, the conversation—how are we going to engage all of you? Bryan and I were talking about the notion of creating a sort of Greek chorus, if you will, Quaker style.

What I'd like you to do for a moment is reflect on what you just heard, what you just saw downstairs, just for a few minutes. Think about how it relates to your own experiences as a physician, caregiver, patient—anyone. If you have a piece of paper and a pencil, you can take it out now and just jot it down.

A: There are always predators ready to mislead us and steal what we have.

Konopasek: That's a good one to begin our conversation, I think. I like the predator idea. It's a good, provocative question to pose to our panelists. Did that resonate with you? Most of our panelists are physicians, and our charge is to talk about caregiving. Is our caregiving necessarily benign and patient-friendly?

Jacobs: I know mine's not. Obviously, medicine is complex, and while one would like to think that people choose medicine for altruistic reasons, there are other reasons to go into it as well. Even some predatory ones, if you extend that far enough. The purpose of the relationship is not always to simply help the patient. If you are a clinical investigator, you're trying new therapies which hopefully will help others, but not necessarily the patient. There is always the financial aspect of it, so if you get one more test on somebody, maybe it's necessary, maybe it's not, maybe you enrich yourself. But it is by no means a unidirectional relationship.

Michels: I made up two lists when you asked your first question. One was what's similar or parallel to the doctor-patient relationship and what's different in the play. My first response when I heard the two were being linked—this discussion and the play—was that I was troubled, because it seems to me there's no doctor in this play. There's a patient, but no one I would think of as a doctor. In that sense the play is pre-Hippocratic rather than parallel with Hippocrates. You have someone who's suffering and in pain and desperately needs Jonathan, an expert in infectious disease. It would probably take him about 20 minutes—he would have cured the patient before you finished the play.

Jacobs: Actually, I think he needed the psychiatrist more.

Michels: I think if we gave him a choice, Jonathan, he would take you. But there's no treatment; there's no doctor. That's not represented there. In a way, the doctor touches on the question of mistrust. One simple-minded understanding of one theme in the play is how his total helpless

dependency links to excessive trust, links to betrayal, and frustration links to paranoid mistrust. That's a normal sequence, and one of the functions of the medical profession is to provide the patient with some assurance of a certain level of trustworthiness. So I think Jonathan was kidding. If I were sick I would go to him and I would know he's making money on the side and I would know he might want to do a research project, but I'd also know that he's been, I think, at Yale, certainly at Cornell, extensively socialized to be my fiduciary, to worry about my needs and to prioritize them. I would also know that his colleagues would look on him with contempt if he violated that, and that would give me a level of trust that I wouldn't have had 2,600 years ago.

Pangaro: My initial reaction was the same as Dr. Michels': what is the analogy here? But after a while I began to see my students' problems. Lyuba and I are very involved in medical education, so the problem of Neoptolemus, who's caught between the masters—the attending physician, the hospital system, the professors, people like us sitting around the table—and the patient seemed to me to be a real one. We know from a lot of work with students—published literature on students—that they do feel caught in between, that we as the teachers don't really understand what we're asking them to do. The socialization, the professionalization, as they see it early on, means a loss of a certain sense of humanity. Now, they get through that phase. They understand that the faculty, the leaders, are actually trying to act on the patient's interest, but that there's a certain dispassion that is necessary, a certain coolness. *Equinimitas* is the term our great mentor, Osler, gave to it: that you needed to be somehow dispassionate to see the patient. But it's a very difficult thing for the student to go through, and Jesse, in acting this today, really caught that sense. I saw my own students in this poor guy who was caught in between. The word that was used—predator—was really—. God, it scared the shit out of me when you said that.

But I think you're right—the patients do go through that. From my perspective as a medical educator, I saw this as a really valuable thing for my students to see: that we understand the situation that they're being placed in. The honesty with which he eventually responds to Philoctetes almost creates the turning point. That's really what happens in the play. Philoctetes is a test for the student, for Neoptolemus. He passes it. And his finally making that decision becomes healing then for Philoctetes. I mean, Heracles appearing is just the way that happens, but it allows the patient to accept it too. So even though I at first didn't understand the analogy and what this whole discussion was going to be about when I was invited, I said boy, this really worked. It was a really remarkable situation of how the young person caught between the system and the patient perceiving the system as somehow predatory or hostile, at best, really fit this medical education model.

Konopasek: Thinking more about Neoptolemus, one of the pieces that I always wonder about is what that experience was. We're sort of talking about the negative sides of the physician-patient relationship. I think we'll move from there. But the lying piece—was it easy for him? Was it hard? The notion of "for the greater good"—do we buy into that? Is lying to our patients occasionally necessary for the greater good or perhaps even for the individual good for the patient?

Doerries: Or for the hospital.

Konopasek: Or for the hospital, which sometimes I compare to the Argive army.

Michels: I think in a well-run system—and that's a big *if*—you shouldn't have to lie to your patient except for your patient's good. There may be lies that are perpetrated, but not by the doctor or not with the doctor's consent. But lying for the patient's good is tricky because it implies that there's an objective definition of what's a truth and what's a lie, and then you do the lie rather than the truth. That's only true in the abstract. The question of a lie usually amounts to the truth value of what someone says. But in clinical medicine, the critical issue is the truth value of what someone hears. And that's not the same thing.

So if a patient says, "Doctor, tell me the truth: do I have cancer? If I have cancer, I'll kill myself." What is the meaning of "You have cancer"? "I think you should kill yourself"? Is that the truth? Is it a lie to say, "Now, let's talk about it some more. You have a tumor but it's hard to specify." Or is that saying I think you should live? So it isn't as crisp as our denotative adherence to the dictionary would suggest. The purpose of the lie, then, is the patient. I get uneasy if doctors lie for hospitals or healthcare systems or insurance companies or their personal income, or stuff like that.

A: What about when the doctor has to get information from the patient that might benefit the society? If a patient tells a psychiatrist that he's murdered someone or he's going to—what about that situation? The patient says, "I tell you this and I trust you."

Michels: That's a sharp, clear question, and the clue to Jeffrey not totally analyzing it is in the careless "or" in the middle of it. He says, "If the patient tells the doctor that I killed somebody or I'm going to," as though those were roughly equivalent statements the doctor would deal with in the same way. But one hundred percent? Not at all—the doctor has no role in bringing punishment to the guilty. He does have a role in protecting. If someone's killed someone, what good does it do to tell the secret? Who do you save?

A: The society from that person.

Michels: How do you know they need to be saved?

A: That's what I'm saying—would you think that?

Michels: It wouldn't cross my mind if someone said, "I killed somebody." We had a patient in a local hospital a while back who told the staff that he had committed murder twenty years earlier. Some of the young students thought they should call the police. It took some wiser heads to point out that that would be a terribly unethical thing for doctors to do to a patient. On the other hand, if the patient says, "I'm going to kill somebody," you don't have to go very far to decide that it's in the patient's interest that you do something to stop it, as well as in society's interest. So the theme is saving lives, not punishing the guilty.

Konopasek: That's an interesting point. Often we think of people in greater positions of power and authority as thinking about the whole system, whereas sometimes it's our foot soldiers, our residents and medical students, who are spending the most time with the patient, who really are thinking about the patient and their situation. So that's a slightly different piece.

Michels: I don't think I agree. I would say the system only works if people trust their doctors, and therefore, the reason I would not tell society that somebody killed somebody is for society,

so when those people in society—all of us, that is—go to our doctor, we know that the ethic of this profession is such so that I can be comfortable sharing my secrets with my doctor, knowing that he won't have some misguided notion of doing what's good for mankind even though it hurts me.

Jacobs: One less clear-cut situation—or perhaps more clear-cut situation—is something that I would think that you would encounter all the time when you're dealing with parents who tell you that they are abusing their children, and knowing you have to act on that confidence, but also knowing that it will probably destroy the relationship that you have with your own patient. It's something that we deal with all the time.

Michels: But it's in the patient's interest to have that confidence divulged.

Jacobs: Not necessarily. If they have their children taken away from them—

Michels: I think it's not healthy to hurt your children.

Jacobs: I agree.

Doerries: Can I pose a question? When you were touching on the patient's self-reporting of "I have murdered someone. I'm going to murder someone," that resonates for me with something that happens in the play quite a bit and something we've talked about with medical students as well—this self-reporting of data which you have no verifiable means of authenticating. Namely, pain and the self-reporting of pain. Philoctetes spent a great deal of the play in agonizing pain. When we worked on those sections in rehearsal, we asked the actors: do you believe Philoctetes? At what point do you not believe Philoctetes, and why?

Konopasek: He looked very perky at the beginning. It was interesting how he was really building the relationship.

Doerries: I raise that because I've spent some time on hospice wards as a caregiver, and I've been in the room when doctors have had to deal with patients who are asking for morphine because they are in excruciating pain, and those patients have developed resistance. They've developed an ability to take twenty times the lethal dose of morphine. They are self-reporting: "I am an 8 on a scale of 1 to 10." And the physicians are giving the equivalent of what you give someone if they said they were a 2 or 3. There's an ethical bind there.

Jacobs: Why do you think they do that?

Doerries: My experience in the hospice ward is because they're afraid of killing a patient who's already signed a DNR. The word "palliative" care, which comes from a Greek word that means "to make easier"—when I go to the Jacob Perlow Palliative Care Center or whatever it's called, flashes of this memory come back to me, of nothing being made easier about the process of dying. By patients' self-reporting pain and doctors either disbelieving them because they have no way of verifying what they're saying, or thinking about the insurance costs of having another person die and having an angry family not understand.

Jacobs: I think that there are a few other elements there. One is who the patient is, because if you have somebody who has abused drugs during their life, even though they're really having pain—

Doerries: Seeking.

Jacobs: Right. Are they seeking medication? That's a huge problem that we have. But we also have the problem that's raised by the play itself, where he says, "Cut off my legs or put me under the ground," and the next line he says, "It's beautiful, this light of dawn." Who are you going to address at any given point, knowing that the situation can change?

Konopasek: The one other piece that I want to take up on that is someone talked about the ambivalence of the illness for Philoctetes, and I think that relates nicely to this conversation about the pain and how much medicine you want and how do you get it. What are your thoughts about Philoctetes? At one point he says, "It's not the past that haunts me, but the future." I think the context, perhaps, was the future of living with the people who had wronged him, but I also wondered if some of it was the future of living without this disease that's been "my companion, the only companion I've had." And, incidentally, the only female element in the whole play, right?

Doerries: A male play, yes.

Konopasek: He says, "Pain, she comes," which I thought was interesting. So his companion of nine years, that ambivalence, I wondered what you might think about that.

Pangaro: Well, he says at one point, "There is no I, only it," meaning "my suffering." So I think you're right: many patients almost consciously or otherwise become reduced to being that and that's who they are, that's how they get attention. It's part of our job as physicians and educators to help students see that as a phase or a state through which you have to just lead somebody out of—that it's not a good state to be in. If he doesn't accept treatment, if Philoctetes for some reason doesn't trust them that there is in fact a cure in Troy: if he goes back he will be cured—

Doerries: Purportedly.

Pangaro: I think it was a given, though. I took it as a given in the play that there was in fact a cure for him.

Doerries: There are classicists in the room. I'm going to be careful about what I say, but as a director, as a translator, as someone who comes to the Greeks to work with actors, we take nothing as given, and this play is built on an edifice of half-truths. It's impossible to know when people are telling the truth and lying, because the lies are predicated upon using the truth to tell the lie.

Pangaro: But in your intro, Bryan, you said we should take it as a given—

Doerries: I gave some circumstances.

Pangaro: Yes, there are circumstances—

Doerries: Those are circumstances that we the actors and director agreed to for this particular presentation, but there are just so many variations on the myth. We have so little commerce with the people who passed it down 2,400 years later. Aeschylus had a version; Euripides had a version; Sophocles has a version; André Gide has a version; Heiner Müller has a version. They're all taking a series of different given circumstances as self-evident. Those are the ones we took.

Jacobs: It's like a White House press conference.

Doerries: Greek myths—yes.

Konopasek: That moment that you talk about, where he's promising a cure, I thought that was very interesting because I wasn't sure whether to believe the given or not. I'm always struck by how we give information to patients—how much of it we believe ourselves, how much of it is our hope and our faith. I was also struck this time particularly that Philoctetes did not buy it. He was so convincing and Philoctetes did not buy it. He wasn't going to Troy. It took that deus ex machina god coming down for him to believe it.

Doerries: Well, I wonder about that. I wonder about the subject of non-compliance, because it seems like there are so many diseases out there that—some of the statistics I've read and, again, there are doctors in the room, so please correct me—but there are many diseases that plague modern humanity where a predominant amount of patients—over fifty or sixty percent—are non-compliant with their treatment.

Jacobs: I would correct one thing, which is—again, in my field and in particular HIV—we've gotten away from the term "non-compliance." Now it's "non-adherence."

Doerries: Thank you.

Konopasek: It's like coming together rather than bending.

Jacobs: So we're not victimizing the victim.

Doerries: This is a White House press conference.

Jacobs: Yes. Yes.

Doerries: No, I understand. I apologize if I offended you. But that being said, Lyuba works with pediatrics, who are so unlikely to take the medicine they've been prescribed in a regular way, diabetics who let their insulin get out of control, lung transplant patients who smoke cigarettes because that's a means of control over the fact that they're in this position. I wonder about that issue of non-compliance and what you heard in the play today with your experiences as physicians.

Pangaro: It was contaminated here because Philoctetes has feelings about the system, which he thinks has been grossly unfair to him. To some extent, his willingness to go along with what might be a treatment has to do with his acceptance of the people who have victimized him to

begin with. I'm not sure it's directly analogous—again, whether you see this guy as a veteran of the wars—but certainly patients often feel victimized.

I was twenty years in uniform as a military physician. My wife and I work at Walter Reed Army Medical Center, where there are young men and middle-aged men and women with wounds that are festering in their legs because of explosive devices. Some of them are lucky in that they've had amputations and they don't have legs or arms anymore. And I use the word "lucky" with an advisory. This is a very painful play for us to watch because of that analogy, and some of these veterans feel terribly victimized—not by having been there but about what happens to them when they come back. Most of them feel that their lives are saved and they got good care, but once they got past the doctors and into the system, the medical care—. You read *The New Yorker* and the picture on the front of the magazine in March was very painful for us, because it looked like the doctors were abandoning the patients and it seems to be the system beyond that. It's very difficult when you feel like you've been in combat and you were there helping the mission. You went to fight the Trojan War. Society had to do it and these people screwed you. They're not taking care of you. So I can see how Philoctetes could say—compliant, adherent, whatever jargon you want to use—"Why should I trust these people?"

Jacobs: That's another reason why he might say it's not the past that haunts him, but the future.

Pangaro: Yes. I think you were saying this before. In order for us to take care of patients—to play our role, whatever that role is—there has to be this bond of trust. I don't imagine there's anybody in this room who hasn't been a patient at some time. I know when I go to my car mechanic I say, do I trust this person? You were talking about how they profit from changing my tires and axles. Imagine how you feel if you don't trust your physician. And if the whole system is out to get you—. I'm shocked how this play resonates with us at this point in time. It's a little scary for me.

Nersessian: One of the things we were wondering if you could address is what you just said about the fact that there are situations where it's painful for the physician. How do you handle those, especially in your position at Walter Reed?

Pangaro: Well, this play gets it. There are two aspects to the pain. The thing that struck me is what Odysseus is arguing for is the greater good, the mission. Odysseus is always the guy who lies and says to lie. But for the purposes of this discussion, I'm going to say that he really believes they need to win this war.

Doerries: Sure. He's saving lives.

Pangaro: It's been going on for ten years. It will save lives if we can—

Doerries: Absolutely.

Pangaro: Even if we have to dupe this guy, there is a greater good here.

Doerries: They're all right.

Pangaro: Yes. In the military, it's very clear that the mission comes first and the pain of the individual, whether it's my own as the physician or the individual, is secondary to the mission, because we believe we're serving the greater good, the country. As you probably know, the military, for many years, doesn't make these decisions about what happens. It's the government. It's the people who are now dressed in ties, like I am, in the Pentagon or the White House who make the decision. And you are supposed to put up with your own personal pain or accept the pain of your patients for the sake of that greater good. What is supposed to help us is the Geneva Convention that says that there are certain rules. For twenty years I carried a card in my pocket that said there are certain things I must do and certain things I may not do.

Jacobs: Have you thrown it away?

Michels: It's a collector's item.

Pangaro: I retired from the military ten years ago, but it's—. I'm not being facetious when I say it's a very difficult question for physicians in uniform at the moment, who are trying very hard to behave ethically and to put up with things that they're not sure about.

A: An aspect of trusting the physician is the message parallel to the patient who says, "I'm going to suicide"—the cry for help. The same thing as you were talking before about the patient who confesses to child abuse. Even if they knew the legality of reporting, it could be a message to the physician: "Can you find some way out of reporting me to help me get out of the situation, to stop me?" One other question: I'd be interested in what the actors have to say about the issue of manipulation and truth, going through the experience of it.

Konopasek: So I'm going address one piece. Do you want to—?

Michels: I want to go back to where we were at this point. We started with the issue of non-adherence, non-compliance, and we took up two extreme cases of it, which is the patient who doesn't follow the doctor's orders, or the soldier who is torn between the mission and his personal safety or health. But really it's a universal situation. Who has never not complied with what he was told to do by parents or the school system or the government or society or the culture or whatever? Who hasn't felt betrayed or in conflict over their personal interests and the greater good? Those are universal situations and all you have to do is look at the incidence of obesity or poor diet or non-exercise or terrible self-care. In the last estimate I saw, fifty percent of the total burden of illness is due to behaviors: drinking, smoking, addictive behaviors, non-adherence to medical advice.

It's a universal theme of being human rather than a special circumstantial theme of being a patient or a soldier. To me this is where we can again go back to what the medical profession is all about, because the difference between 2,400 years ago and now—one difference—is that we've reached a cultural decision that it's for the greater good to have a designated group of people whose mission is helping the individual, rather than imposing the social order. Doctors emerge and they're odd because they're certainly serving the greater good, but they're doing it via a very individual situation: serving the patient's interest rather than society's interest. But the net effect of that is good for society. They're not unique in that. It's true of the law also, where we say we'd rather live in a world where every lawyer is working for his client rather than

having lawyers impose what the society believes is best, because in the long run, that'll be a better society.

Pangaro: I think Bob's analogy and description of the situation is right. However, I'm worried about the evolution or the change in the medical profession here. There are mandates now about seatbelts and we say that the individual is important, but there could come a time, because of the increased cost of medical care, where the government may say to the individual, "If you are not adhering to your medications or if you do not control your diabetes and asthma, we're not going to cover or pay for your medical care." Then all of society is going to be involved in a discussion about whether or not we're going to pay for the medical care for the non-adherent. And then physicians will be agents, not in the future of the individual, but more directly of society.

Michels: Still, the caretaking physician doesn't worry about who pays and who doesn't. That system does. But by the time you're the doctor to a patient—most doctors I know don't fail to treat the patient because the patient can't afford them. If the patient gets in their office, they treat them.

A: Unless the lady at the front desk turns the patient away because she doesn't have the right card. I have had this happen to three friends lately, in physician and dental offices where they had a long history and were very well-known. When they got to the doctor himself, he was terribly mortified: "Oh, I would never turn you away, dear." But you would let the lady at the front desk handle that for you.

Konopasek: Just to add one more piece: the notion of adherence and pay-for-performance, so that physicians are actually going to feel fiscally the price of their patients' desire to adhere or not, which I think is going to have some grave implications for the medical encounter. It's also going to add, I think, to what you were just saying, that you might be turned away at the desk. It's interesting, when I first heard about pay-for-performance, I thought, great. Finally, physicians are going to be encouraged to really communicate effectively. But I think the risk is that this might be another way to select against a certain kind of patient.

For me, one of the pieces that is very interesting about this play is this question of who owns the illness, and in terms of our patients, that question of their decision to adhere or not. I think that's a nice question for Jonathan, given his work. What's your thinking about that? Who owns the illness? There's the micro-question for the individual patient, and of course the public health issue. What's your thinking?

Jacobs: I think in terms of, again, my particular interest of HIV. We all own the illness, because as this play demonstrates, there's this snakebite that caused this pain, but it's really the social factors—the isolation—that creates so much of this man's misery. I think that for any chronic disease, you probably have to consider it in terms of the social determinants. It's impossible or very difficult in this country, to take care of chronic illness for people who don't have insurance or are impoverished. There just aren't systems in place to do that. So again, I think it makes a difference, most of all to individuals, what happens as a result of that snakebite. But I think that we can certainly—all of us, not just physicians—modify that suffering person's experience by the social reaction. Of course in terms of HIV back in the '80s or what goes on in the world

now—it is that stigma, that discrimination, that "don't get on my ship," that really helps to fuel this epidemic.

Konopasek: How do you manage the patient that refuses to take their meds?

Jacobs: I think you have a couple of choices. Earlier in my career I'd get very mad at that patient not following my orders. But now I realize that in order to keep any chance of keeping that person in care, I have to work with them and try to understand why they're not adherent. Again, is it because Medicaid shut off and they can't get the papers together to get it back on? Is it because they're scared that someone else will see their medication? I think it's something you have to investigate. We are not a nation of medically literate people for the most part, so we have to educate, because some people don't understand. I feel perfectly well. I may have this disease, but I feel fine today. Why do I have to take this medication? The fact that I know why they have to take the medication is a lot different than them knowing why they have to take the medication. Educating both sides is critical.

Doerries: One of the things that I wanted to also bounce off of all of you that resonates with what you're saying is that one of the things, Bob, that I think has changed since 409 BC about medicine, is just what you said, and also remarkable advancements. But it does seem, from a patient's perspective and reasonably from my illiterate perspective, that we are at a footnote juncture in the history of medicine. We're fifty-two or fifty-three years past the successful kidney transplant. We're now in the business of creating a permanent subclass of people who are neither well nor sick and live for decades having to worry about the question of adherence when they don't know it's all going to end, where there's no cure at Troy waiting for them, just this permanent state of being neither well—

Jacobs: Limbo.

Doerries: Yes, this Bardo, this liminal state. Certainly the mortality rate was high for infection in the ancient world or for chronic conditions. So I wonder about the question of adherence.

Michels: From an epidemiologic point of view, what you're saying, I think, is that what people like Jonathan have done is turn acute, fatal illnesses into chronic disabilities. Therefore the community is now divided into two groups of people: those who are chronically ill and those who are not yet chronically ill. And that's it. You're either in one category or the other. Unless you're one of those unfortunate people who's going to get hit by a truck before your forty-fifth birthday—that's a very small group.

Levy: What about the professional patients, the people who seem to almost exult in their identity of being patients. If they were to graduate, they wouldn't be cared for anymore. I wonder—and perhaps there is a bit of untruth in what I'm saying—but it is my perception that there are certain people who enjoy maintaining their relationship with the doctor and sort of perpetuating their condition. I'm not talking about chronic AIDS patients, but I'm talking about the kind of person who has a constant series of ailments, one after the other. I'm going to step on some toes here, but the Chronic Fatigue Syndrome group—people report these strange conditions that go on for years, that have no nosology.

Michels: You're not stepping on my toe. You're explaining to me why I'm here, which I've been wondering about. I'm a psychoanalyst.

Nersessian: Because of your expertise in medical ethics.

Michels: I'm a psychoanalyst. I consider those people chronically ill with a disease that I spend my career trying to treat. Somebody who craves the sick role has a fascinating personality disorder and can be helped often. Fortunately, that particular disorder is relatively treatable compared to some of the ones Jonathan has to treat.

Doerries: But isn't it getting harder and harder to see the forest for the trees? You listed a few ailments and they're the ones that seem pharmaceutically-driven, like restless legs, but what I meant by footnote is that it just seems like we're on the verge of every day discovering a new complex of interactions between genetics and behavior and conditions that result in another chronic name for some disorder that you didn't know you were living with until it was diagnosed. Where will it end?

Michels: I would phrase it somewhat differently. You weren't aware of it because you were dead. The average life expectancy in the United States has, over the last century, gone up about fifteen minutes every hour. Startling. A lot of those chronically ill people aren't people in your metaphor who otherwise would today be considered or labeled healthy. They would today be considered dead.

Doerries: Right. But Philoctetes' question, I think, is: is it better—

Michels: To be dead?

Doerries: To be dead than to be sentenced to a life of chronic illness?

Michels: That's a fascinating empirical question. Let's take the people who know most about it: physicians. If you ask physicians and describe some horrendous chronic illness, the average physician says, "I've seen that in the emergency room or the hospital. I'd rather be dead." But if you ask patients with that disorder, with the locked-in syndrome, who are on respirators, the great majority want to be alive. So the answer is: for the people who know most about it, they think it's better to be alive.

Konopasek: I might challenge the idea that the doctors are the ones who know most about it.

Michels: Okay.

Jacobs: I would say, to make a few points: one is that your response depends on whether you can do what he says in the play: "embrace your pain." Because if you can do that and somehow, as it says in the play, "through suffering achieve greatness," that's one set of people. Most of us can't do that. But one experience that is universal that is not exactly chronic illness is old age, because when I first read this, what I thought about in terms of Lemnos was a nursing home, where we used to have, when I was an intern, something called a "screech sign," where you would take Granny to the emergency room and take off. That's as close to what happened to Philoctetes as I can think of.

Doerries: Oh yeah. They burn rubber.

Jacobs: Even if you're healthy, you can be isolated in a way that's very painful like that.

Konopasek: The other piece that I thought was interesting was the moment that Neoptolemus's view of the patient, Philoctetes, changed. It struck me that he was okay with the lie until he saw the screaming. He was going along with it; the plan was proceeding according to Odysseus's greater good plan. It struck me that it was the moment when he saw a very overt sign of Philoctetes' pain that he suddenly realized his humanity. I wonder what you guys think about that in terms of if that happens in the hospital. Is that the moment when we see our patients' humanity, or is that the moment that we dehumanize them?

Michels: Those are two different reactions. Hopefully, a doctor would sense the patient's humanity before that, and also would be able to maintain an optimal emotional distance from the patient in spite of that. I would say if the doctors, too, identified with the system rather than the patient before that, that's a problem. And if they're over-identified with the patient and lose their contact with the system afterwards, that's a problem. Maybe what medical education should do, if it goes well, is to facilitate an earlier ability to empathize and identify, and facilitate a later ability to maintain optimal distance at the same time.

Konopasek: I think that piece of training, in terms of the boundaries, is something that is not done explicitly in many parts of medical education, except for in psychiatry residency.

Michels: I think it's done implicitly in all clinical education.

Konopasek: Yes.

Michels: I'm not sure explicit training in that is worth much. It categorizes the phenomenon, but I'm not sure it facilitates its actual practice very much. I'm a skeptic about it, I guess.

Konopasek: Do you guys want to respond to that?

Pangaro: I think it's a great question Bob is asking about implicit versus explicit training in the humanities in medical school, the work that you guys are doing so actively. It depends. Some schools pick ninety to ninety-five percent so-called hard science majors—chemistry, biology. Very often the leading schools do that, and so many schools, to deal with the fact that they're taking scientists in, have introduced humanities in the first few years. Certainly interviewing courses in the first year in dealing with students.

But I agree with Bob. We don't have the empirical base; we don't have the research to know what makes a difference. There is a move in the educational community in this country to try to get away from just choosing students who do well on science multiple choice tests as the principle criteria for getting into medical school—that the admissions process will somehow be changed. We know, for instance, that the medical college admissions test, the science part of it, predicts pretty well how you'll do in the first two years of medical school. But the verbal reasoning part predicts better in the third and fourth year. Is calculus, physics, and organic chemistry a necessary entry requirement for your physicians? I mean, this is a place where patients can probably make themselves feel better than somebody who's on the inside, because

they don't listen to us. There is so much inertia in the system. But many people are arguing that psychology and the humanities may be a more important criterion for getting into medical school than calculus. Most physicians.

I'm an endocrinologist: I do a lot with hormones. But I know that biochemistry is not necessary for most medical students to study, even in medical school, much less organic chemistry or physical chemistry being a prerequisite. As you probably know, those things are done as hurdles to demonstrate that you have the cognitive horsepower to deal with the medical curriculum, but how much is enough?

So back to your question: is it a given that medical students recognize the humanity of their patients as the default, or do they have to come to some point like Neoptolemus, when all of a sudden they say, "Oh my God, that's a human being I'm talking to." I don't think we know the answer to that. We don't have good ways of selecting students yet, and we don't have good tests of any kind: litmus tests or comprehensive tests for knowing whether or not medical students are sensitive to that. Our admissions committees try really hard to do it, but I don't think that—

Konopasek: I actually think there's something about the training and the implicit learning, the learning through the hidden curriculum—what you learn through role-modeling and what you see on the floors, what you see other physicians doing—that might actually—. My first-years would be like Neoptolemus. I don't know if all of us as third-year, fourth-years, and residents would be. You are taught different coping strategies for when your patient is in that much pain. And that's a troubling piece for me. On one hand, I see the need for us to learn coping strategies and the *Equinimitas* that we were talking about to provide effective care. On the other hand, how do we do that and at the same time not abandon our patients at those very moments. Because Neoptolemus does have the option of just running away at that moment. The system is telling him it's the easy piece. What do you guys think about that?

Jacobs: One positive development is that—at least talking about medical training—the workload has been reduced so that we have the time to be empathic with people. When I was an intern, there were people with leukemia who were suffering, who took up a lot of my time. And you know, being pulled in another direction to do something else and spending time with this patient—it was not a very humanitarian way to try to train, I don't think. I'm very glad that work rules have abolished that particular conflict. I think that physicians also self-select for various fields. Again, I'm not going to say which fields people might go into if they find that they have a hard time empathizing. It probably works both ways. You might go into oncology because you have achieved the equanimity, or you might go into oncology because you have this great passion for people who are suffering. But I do think that we sort ourselves out to a certain degree.

Pangaro: I think you're bringing up the concept that we call "the hidden curriculum." Just for terminology, here, what Lyuba is referring to is that the explicit curriculum is anatomy, physiology, biochemistry, medicine, surgery, and pediatrics. It's basically the syllabus, the content you want students to learn, but students learn and residents learn that there are certain things you do. If you refer to the Philoctetes kind of character, who for us is the problem patient, the difficult patient, the patient who's in pain, and if you learn, "Oh just turf it to somebody else. Draw the blood test, do the CT scan, let somebody else do it"—if that's what your "role

models"—the term Lyuba used—are doing, then what the hidden curriculum teaches you is that's what you'll be rewarded to do. What patients and society needs to understand is that by and large, physicians are not paid to talk to patients. In fact, the current Medicare rules make it very hard for internists, pediatricians—I can't speak to psychiatrists—but if you spend time talking to a patient, you're taking that away from your income and your kids' tuition for college. The Medicare rules very explicitly punish physicians who are talking to patients. I'm speaking for myself, here, not the United States government. The hidden curriculum teaches you to order tests. Somebody else's time is being used.

If Medicare pays you for nine minutes—my patients are seventy-five years old, have seven or eight problems. I need thirty to forty-five minutes. One of the great things about the federal government—this is an argument for national healthcare—is that physicians' incomes are not directly related to their efficiency in the managed care system. I can spend time with my patients. I may be longer at the end of the day, but my income is not directly punished. That's what I like about the military healthcare system. But my colleagues, my friends who are in practice, they think I'm crazy, spending forty-five minutes with a patient. "Why would you do that?" I need to talk with my patients; they're complicated. But your system that your society has endorsed certainly doesn't want to incentivize talking to patients.

Jacobs: That's why that I think—going back to the original question about trust and doctors—that you may be right, Bob. Doctors are trying to do the best thing for their patients, but the systems in place, whether it's managed care or Medicare, make it very difficult, if not impossible, to actually be as thorough as your conscience tells you to be. So you just order the tests and don't pursue why they're coming back for the third time with chronic fatigue.

Michels: The current evolving system makes a fair amount of doctor/patient contact with people the doctor doesn't experience as his patient, but just the current person he's interacting with. When I graduated from medical school, the modal physician was in an individual practice where he had an office and people came to see him and they were his or her patients—mostly his, then. There was no question whether you had a patient or not.

Now the typical doctor is an employee and not in practice by himself or herself. Frequently the patient is the patient of a group, who not infrequently see whichever doctor is up that day to see the patient. One of the most popular specialties in terms of growing popularity in the last decade has been emergency medicine, where the typical encounter is once with a patient. And it's heavily protocol and algorithm-driven. All of these are powerful, structural, de-professionalization things, and the question is, can we develop a socialization of professionalization that will survive them? I would say the evidence so far is a little, but not all the way. There's a deep professionalization of medicine because of it, in terms of the qualities of personal relationships between the physician and patient. This is an un-discussed price of the evolving healthcare system.

Konopasek: Should we open it up? Do you want to come to the microphone? We welcome your questions.

A: It's not really a question. I've been listening with great interest, but I'm one of the classicists in the room, and let's remember what Aristotle said about pity and terror, which he said are

crucial in the cathartic process. The scholar Northrup Fry kind of gave a demotic version. He said, "If you see somebody run over by a car, pity is what makes you reach out to them and terror is what makes you think, 'My God, I'm glad that's not me or anyone I care about.'" It's hard to think of a better example than Neoptolemus of pity and terror kind of localized in one person in one situation. I would leave it up to the doctors in the room to carry that ball further, but I was just thinking we shouldn't forget tragedy. That's it.

Doerries: I have a comment to respond to that, and I think there are people in the room who could also speak to this. There's a theory that's been developed and is being discussed. It's not necessarily new, but it's being written about by psychiatrist Dr. Jonathan Shea, some of whose students and friends are in the room today. Unfortunately, he couldn't be with us. He's written two books about post-combat stress through the lens of epic. Lou, I don't know if you've read *Achilles in Vietnam* or *Odysseus in America*. His theory is that Greek tragedy—and Aristotle's catharsis, even though it's over one hundred years later that he's writing about it— can only be understood through the lens of a theater by veterans for veterans. In other words, Euripides, Aeschylus, and Sophocles all saw combat, and the presumption is that a large amount of people who were in the theater of Dionysus in the 5th century had seen combat, whether they were enlisted men or all the way up through. So this idea of pity and fear resonates on a different level, with the idea that veterans may not have a vocabulary—I think just as chronically ill patients, only being 150 years into this era of chronic illness, do not have a vocabulary to discuss the things that happened to them or are currently happening to them. It's only in the presence of other people who have had those experiences, in a theater, with a play that deals with a wartime subject, that implicitly, silently amongst those people who are there, a form of healing or catharsis could occur.

Jacobs: In terms of your introduction to the play, you mention that he wrote this when he was eighty-six or eighty-seven years old, and this was one of the later plays that dealt so much with isolation. In addition to his wartime experience, I think the aging process and that isolation comes through.

Doerries: Absolutely.

Konopasek: Can you tell us what Sophocles was going through at that time? It's really interesting.

Doerries: Yes, there's a story—and again, the classicists can speak to this—that Sophocles at age eighty-six or eighty-seven, around the time that he wrote this, had been taken to court by his two sons and was to be declared mentally incompetent so that they could take over his estate. Sound familiar?

Jacobs: It's called a "screech sign."

Doerries: He purportedly recited lines from the chorus of *Oedipus at Colonus*, which as many of you know, ends with a blind, old man facing his death, wandering alone through the desert, essentially. Then he said, and I'm paraphrasing, "If Sophocles is mentally incompetent then I am not Sophocles. I am Sophocles and I am not mentally incompetent. If Sophocles is mentally incompetent, I am not Sophocles." He won the case and his sons were censured.

A: Yay!

Doerries: And he continued to write. But this is a man who clearly knew what it meant to be isolated by his family in his old age.

A: I've always looked at doctors as healers. There were some comments about how we can't spend as much time with you because of insurance. At one point in time I had a doctor that would talk to me: "How's the family?" Just sit and find out how my marital activities were and things like that. That's one thing that's gone. I look at doctors as caregivers, and most of my doctors come from Cornell. I've never had a doctor there at Cornell, or a special surgeon, which I use quite a bit, turn me down because I have coverage. But there are one or two doctors that say, "I'm not taking any coverage."

That makes me a little bit angry. It sort of suggests, "I want the money. The hell with you. I want the money. You want to get special healing? I'm a specialist and I'm the best. Screw you. If you don't have the money to give, then I don't want you." That, to me, is kind of cynical and it's something that bothers me. Thanks.

Pangaro: May I comment on that? I'm in the military medical system, so it's basically a HMO that is government-run. So I'm not directly in that system, but I have friends who tell me that one of the reasons they've stopped taking insurance of different kinds is they're trying to give a message through their patients to society at large and to the corporations. Do you see what I mean? Many physicians don't feel like they have any power. So they're using you inappropriately to send a message to Congress or someone else to say, you need to do this, because if we say something, nobody's going to listen to us. But if patients and voters do—. I don't know if this is plausible in your circumstance, but I think what they're doing is they're trying to send a message.

Michels: Continuing with this theme—your feelings are important, but they're the feelings of someone who has access to healthcare but not to a small group of doctors. Forty-five million people in the United States have no access to any doctor because they have no insurance whatsoever. Every recent poll shows that the American medical profession wants universal health coverage, even if it means a diminution of their income. They want universal coverage because they hate this social arrangement. The citizens of the United States have voted for people who don't want universal coverage, so your passion is well-taken, but it may be aimed in the wrong direction.

Jacobs: The other tangential point I would make is that obviously there are physicians you can't see at all, but the physicians that you can see who are no longer asking about your family and how things are going at home may be missing the key to the diagnosis.

Konopasek: Just to add one more piece. In terms of our professional duties as physicians, and I think I learned this from Lou, you can distill it down to two words: duty and excellence. The duty part is social justice. I think that certainly the profession has a sense of where we should be going, and then the question is how can we make the system allow us to go there?

A: I think some of these questions are an issue of rationing medical care. Even in this play, I was intrigued by the fact that they left Philoctetes on the island. I don't think it was punishment, though we could look at it that way. I think they did it for humanitarian reasons, not to kill him, which I thought was unusual for the Greeks, because they killed even girls, just to have a better military or whatever. As far as the rationing goes, I think it has to do with killing these sick people, such as Philoctetes. But I was intrigued by the article in the *New York Times* today, where there is criticism that the killer in Oklahoma City received only $265,000 in medical care. I mean, where do we draw the line in the rationing of medical care? Do we kill these people like Philoctetes, or are there unlimited resources?

Konopasek: Just responding a little bit to that question of why they didn't kill him to begin with, which I think is really interesting—. I guess this speaks a little to the power of the patient, which we have sort of skirted around but haven't addressed explicitly. We've talked a lot about the system; we talked about the physician's responsibilities; we talked about the complexity of practicing in the year 2007 and all of the different forces at play. What are your thoughts about the power of the patient in the year 2007? Perhaps Philoctetes wasn't killed because he had this divine bow and arrow. Perhaps he was tricked onto the island.

Jacobs: It does say he was abandoned there because he was interfering with their libations.

Doerries: Yes. They were trying to make a sacrifice and he was screaming, which is a real thing for them. Whether you make a good sacrifice or not will result in physical realities.

Pangaro: Well, to return to what Bob was just saying, the power of the patient. There are different kinds, but here we're talking about political or social or economic power. We're not yet at the point where most of the public in the United States is educated about medical care and educated in the political system and how it works, where democracy is really working. Basically the difference, as I see it, is that democracy is not working at the level of the individual. It's various interest groups that are working. The different factions that Jay and Madison tried to neutralize when they created the checks in powers really isn't quite working.

I think what we hope in the profession, since we're not happy about how the medical system is working, is that people will vote for politicians who will change the system. That's the kind of power, I think, the patient's—since everybody sooner or later is a patient, whether preventively or eventually because they have a problem—that somehow the educational system will get them to the point that they will vote for what we would like to see happen. But I don't think the profession—certainly not my generation of the profession—has done a very good job of educating the public. I'm in internal medicine, so the American College of Physicians has only for five to ten years tried to get into the public educational arena. As a faction, the American College of Physicians is trying to get the public to understand that if you want internists who deal in complex adult illnesses—very complicated illnesses—if you want us to do what we're trained to do, you've got to vote for it. Because if we push for it, it will be perceived as self-interest.

Jacobs: One other fact is that all four of us are in academic medicine and the medical leadership tends to come from academic medicine, which is somewhat removed from these day-to-day

practice situations. I think the medical profession has had to educate itself and then we're getting late into the game in educating our patients.

Konopasek: What about in the individual physician/patient relationship, in terms of the balance in power? How has that changed, do you guys think?

Michels: Well, certainly there has been a huge change in the apparent balance of power, in that only a few decades ago the doctor was all-powerful, and the patient was supposed to be compliant and take orders Doctors would make decisions and patients were told what they were. The patient's power was then hidden. The major power was that the patient could leave.

The last statistics I saw were about 35% of all prescriptions that doctors write are filled, which means about 65% are not filled, which is very interesting if you think about it. That's a form of power. If the ability to write prescriptions is a form of power, the ability to throw them away is also a form of power.

In the last few decades, there's been a sea change in the attitude toward what "good medicine" is and what's appropriate. It's part of a broader cultural change about the de-authoritization of pseudo-authority. The compliance-adherence shift is a symbol of it. It doesn't mean much except what it symbolizes. And the notion that for patients, particularly with chronic illnesses, still the anesthesiologist or the ER doctor is an authority, particularly if the patient is in a coma. I just came from a conference on the care of patients with vegetative states or minimal consciousness. Clearly, the doctor is the authority if the patient's unconscious. But when you get chronic illnesses, I would say most strategies of treating them today—I'm going to say something that no one else in the room will accept, except maybe Ed—are borrowed from psychoanalysis, where the goal is to teach the patient everything you know about his or her illness so that the patient can be in charge of his own management and treatment.

Jacobs: But then they have to come in every day. It's not practical.

Pangaro: I want to pick up that notion. There is growing evidence, and physicians like to use empirical evidence, that success is not what happens in the doctor's office or the hospital, but what the patient achieves in their own home. I have many patients who have diabetes. I say to the patient, "This is what you're going to do: you're going to take insulin. This is what's going to happen. I'll see you in four weeks." It took me about five years of screwing up to realize that wasn't working. You have to basically get the patient to the point where they can participate in their own care to the extent that they want to. Otherwise you fail, and sometimes miserably.

But you and I both use a system which we call the "RIME scheme": reporter, interpreter, manager, educator. I'll basically explain what it says. In order to succeed as a physician, you have to educate the patient to the point where they can participate in the decisions, because they're going to throw out the prescription or not. This is still controversial in medical education, but the notion is that if a finishing resident about to go into independent practice cannot educate the patient to the point that the patient can participate, then that resident is not yet competent and cannot go into practice. This is a notion I introduced about 15 years ago. It's still very controversial at the student level and the resident level, but the Institute of Medicine adopted this notion in what they call "patient-centered care." And I think things are moving in that direction.

Now, what it means then—and this is where I'm hoping the public will come alive with the educational process—is that the physician must not just be a manager telling the patient what to do, but an educator. Then we have to give the physician time to work with the patient and physicians have to be paid for it. This requires a reeducation of the physician and the public along the same line, and it's an economic and political discussion that needs to happen. I think the public will want that, and I think the empirical evidence is from diabetes, asthma, and I'm just talking about my own field of internal medicine, heart failure. My guess is it's true in HIV. The patient must accept and participate in the discussion or it fails. Therefore, we have to incentivize a discussion.

Michels: I agree.

Konopasek: It sort of goes back to that performance question. And just to add onto that, the notion of shared and informed decision making that is really shared, not just "I want you to do this and here's the prescription."

Jacobs: I must say that it can go the other way also, because the person who comes in with a cold says, "I want antibiotics. Where's my prescription?" That also is—

Konopasek: That's not shared or informed.

A: My question is about assisted suicide, which I would link to the play by Philoctetes' desire to die. I speak as someone born about ten months after the end of World War II, as early a Baby Boomer as can be, and also a professor, who therefore is thinking in terms of the medical burden the people my students' age will cover as we, people of my age, are kept alive longer and longer. It inevitably strikes me that here, those of us who want assisted suicide because we don't want to be kept alive in a poor quality past 100 or whatever, have a natural community of interest with the students' age group, who don't want to have more and more of their income given to this perpetuation of us. I wonder if any of you would comment—the thought was jogged by your statement about what will the voters be doing in the future. Our voting block, the Boomers, is very big, and I make the joke that we tried to take on what we thought were the most essential issues of our time ever since we were undergraduate. It may be that we have not done so well, at least in the earlier decades, but that our crowning contribution as a vast, aging voting block, might be assisted suicide. I'd like to hear your comments about that.

Konopasek: Bob, that sounds like one for you.

Pangaro: Yes, definitely.

Michels: We have some empirical data about assisted suicide. There are places where it is legal and available, and one of the most striking discoveries is how rarely it's used. So its public health significance, in terms of the burden to society of the elderly or the ill, is negligible. That doesn't take away from the moral question or the professional ethical question or the legal question, but it isn't an economic issue. It's too small in number. My own view is that two conflated issues should be separated: one is an individual's right to determine whether or not they live—suicide, the other is the physician's role—assisted. I don't think it's a good role for

physicians. It's actually extremely easy to kill yourself. I don't think you have to go to medical school to do it, so it seems to me that it's easy to split those roles.

When physicians look at people who are interested in assisted suicide, there are several things they observe. One is a significant number of them are depressed, and if you treat their depression, they no longer are interested in assisted suicide. It sort of feels funny to let someone kill themselves when they're depressed and I know I can treat them and get them out of the depression. And they'll say, "Thank you for helping me be less depressed. I almost killed myself. I'm glad I didn't." Knowing that, I feel that somehow or other we should have a social structure that allows me to treat them even against their will, if the relative balance is between allowing them to kill themselves when they'll turn out not to have wanted to, or keeping them alive against their will for a few extra months. The second observation is that the availability of assisted suicide leads to a very, very uncomfortable pressure from family and society for people who have illnesses that are burdensome to avail themselves of that opportunity. I'm not sure I want to grow old in a world in which, as I get a little older and a little more infirm and a little weaker and a little more decrepit, my children begin sending me Christmas presents of books on assisted suicide.

Nersessian: Or just send the pills.

Michels: Right.

Doerries: Just to tie it back to the play, it is worth noting that Philoctetes was given the gift of the bow by Heracles for having performed an act of euthanasia by burning Heracles on a pyre when he was consumed with pain by an illness brought upon him by a centaur named Nessus, and that the myth of the gift of the supernaturally-accurate bow is deeply tied to the humanity, from a Greek perspective I think, of Philoctetes' actions in choosing to euthanize this man in pain.

Michels: And Philoctetes was not a doctor. I'm not against assisted suicide. I'm against physicians assisting suicide.

Konopasek: Right.

Doerries: Sure.

Konopasek: Bryan isn't condoning it.

Doerries: No, I'm not condoning it, but I do think the point is that it's very difficult to ask someone. It may be easy to kill yourself. I can't argue with that. But I think it's difficult to ask someone to do it alone. Maybe that's at the heart of this issue. Most of us don't feel medically competent enough to help someone kill themselves.

Michels: Twenty minutes on the internet.

Doerries: Sure. Maybe again it's about developing a vocabulary with which to even have a conversation in a culture where it's so culturally taboo to talk about suicide, and that we all feel alone when we contemplate the idea of helping someone do it.

A: I'm going to start another roundtable. A number of points came up in the course of this that I'd like to address and one of them is this business of the—. Well, let me tell you the story. I was vetted for a professorship in medical school and had to make the rounds of the departments. The Department of Medicine met me after fifteen minutes of waiting and said, "Why do we need a psychologists' medical school anyway?" I said, "Why don't half of your patients not fill their prescriptions? And the half that do, never refill them." End of conversation. These are psychological issues.

As Dr. Jacobs mentioned, we have graduated from compliance to adherence. Medical sociologists now want us to go to cooperation, which is the main issue we're talking about. How do you educate your patients? But it's not just to educate—educate means to lead out of—but to discuss with patients not why they're not doing what we tell them to do, but what are they doing? In teaching my students clinical work, the main thing to get them to do is to say, it's not what the patient isn't doing, but what he is doing that should be your concern. There's no nothing in this business. Patients are always doing something, even when you think they're not doing what you want them to do. Find out what *they* want to do.

I think that comes back to Philoctetes. Is Philoctetes the correct pronunciation? Do we have any idea how to say that? I stand corrected. I know what they said about the Romans: no one knew how Latin was spoken anyway. Achilles' son had a point where he changed his mind, and I think it was when he recognized that he could not any longer deceive this man who had trusted him. No one's talked about the physician's burden of trust, what that does to you when all of a sudden a patient looks at you and says, "I'm in your hands, Doctor." That's a terrible burden, you see. And the boy could not take it. He could no longer be part of an untruth in his own terms. It was the higher good; he just couldn't do it anymore. That was the power to the play, in my mind.

The other is that Philoctetes' problem was not addressed by anybody. He was suffering a great common conflict in our psychiatric patients: that of pride versus pain. Shall I reward my enemies even though it causes me this pain? Wouldn't I do better to stay on this island rather than betray my principles? That's a very powerful thing. Unfortunately, it's rare in this climate. We don't have our political leaders asking such questions of themselves.

One more thing: the issue of the patient asking for assisted suicide or asking for pills or asking for anything else. To teach our young doctors and psychologists and therapists the enormous power the questioning form has. To teach them not to ask patients questions. Let them tell you. Don't interrogate your patients, you see. You want the patient to tell you the story on his terms because what he doesn't tell you is as important as what he does tell you. You know the right questions to ask, anyway. But when a patient says, "Can I tell you this secret?" You know he's only telling it to get it off his back. The only reason to tell a secret is to tell it to somebody else. We are enjoined to do something with this information, not to not do something with it. And that becomes a topic of conversation with a patient. "You want to commit suicide? You want my help? Let's talk about that. I'm not sure how the best way to go about it would be."

Konopasek: Nicely said. It makes me think we usually teach our students to *take* a history, as if we're extracting something. There's some literature now about the notion of building a history together, rather that extracting it.

A: All you get are lies anyway. When the present changes, the history changes.

A: Thank you for this terrific discussion. Since 1990 I have worked with medical students, residents, and nursing students coordinating standardized patient programs, training standardized patients, and giving difficult diagnoses and taking histories, teaching breast self-exams—lots of different subjects. In the second year of their training, medical students are very open to this. Later on, residents are open but guarded, because they say, "Well, how can I really do this kind of model," which is very much incorporating the patient as a partner in their own care and listening to patients and educating patients. "How can I do this with the constraints in the real world that are put on me because of time pressures and money pressures?" I don't always have a very good answer for them. I'm just wondering if you can help me. What I say is, "I'm showing you an ideal, and try to adapt it in the real world." But if you can help know how to advocate or at least just address this reality, I'm open.

Pangaro: I think what your residents are telling you is what physicians in practice see: that there are certain incentives and pressure to perform in a certain way, despite what we do in medical school. There's an explicit curriculum, there's going to be a reality. Gradually, it's evolving, though, and I think you should be very optimistic that your work with standardized patients and helping students, residents, and even physicians in practice use certain skills in interviewing, in building a history together and what we call 'giving bad news' or working with difficult patients, is paying off enormously. It's not going to be as quick as a new treatment for diabetes or heart failure; it's a gradual thing. It's going to take a generation or two. Standardized patients has been around since the '70s, but in only about ten years has your work really permeated almost all medical schools in the country. So I think you should be optimistic that it will in fact gradually change things, but ultimately, it's only going to work if society, through education—and I mean grammar school and high school education—is willing to support changes in the healthcare system and payment system. It's not just something that medical educators, the people in the academic center, can do. It's got to be a social change.

Jacobs: The other thing you can tell the residents is to be like Achilles' son and stick to your principles. Don't be influenced as you go on in medicine by the cynicism of the Odysseus types around. Again, I think we have great people going into medicine these days if they pay attention to their own core values.

Michels: I think there is maybe something to add, which is the phenomenon you're describing and linking to the pressures of the current healthcare system was described way before the current healthcare system. Probably the most famous study of medical education was done by a medical sociologist, Renee Fox, who went through four years of medical school as a participant observer with a class at Cornell before Jonathan or I were there. She coined the term "detached concern" to describe the attitude that medical education socializes in the medical student/physician. She pointed out that the typical freshman coming in is very humane, very empathic with patients, very concerned about their feelings, and often anti-establishment. By the second year of residency, the language has evolved, so patients are Gorks or Cauliflowers or they're things in beds and they're totally dehumanized.

Five years later there's a move back somewhere between the two. She saw that as an essential evolution of their ability to detach themselves enough to be professionally effective. The last

thing in the world you want is a cardiac surgeon with his finger in your heart who is empathically identified with your pain, and therefore does the wrong thing. In order to develop that detachment, there may have to be a phase in which you're hyper-detached, and medical education may inevitably do that, although our current stresses of the system may make it excessive.

Konopasek: I think the one other piece that Lou talked about and that you're hearkening to, is it used to be that this was only taught or paid attention to or evaluated in the first two years of medical school, in the absence of medical knowledge. Physicians are trained to communicate with patients before they know anything. We are now watching them much more in the wild. We're not just watching them in the classroom. And we're evaluating them. What Lou was talking about in terms of measuring competence in communication skills, this is a sea change. A resident used to go off and become a resident and their job was to provide patient care. There wasn't that much assessment of what they were doing in terms of communication skills. Renee Fox was watching. She was one of the few people who was watching what was going on. So I feel a measure of optimism about what we have now. There are pressures from the system, but on the other hand, the educational system is at least allowing us to look at what our residents are doing. Because inevitably, if all of us are going to one day be the chronically ill or one day be hospitalized, the people who are going to be caring for us are the residents.

Any concluding thoughts?

A: My husband was going to be looking for a new physician and I thought, well not only is it important for my husband to like this physician, but I thought it was important, as his spouse, that I liked his future physician also. My husband made an appointment with a doctor he was referred to and we were ushered into this doctor's office. The first thing that he did that I liked was that he asked me to take a chair that was not really in the corner, but away from where I knew they would be sitting. It turned out that they were sitting just about maybe a foot away from each other because this doctor was not sitting behind his desk. He was sitting just opposite my husband. I thought, Oh, I really hope that my husband likes this doctor because I just think that this is really terrific. It was a simple move and sort of a psychological move. I had never been to a physician who ever did that. They sat behind the desk, and I sat opposite them. So my question is to Dr. Jacobs, who is my husband's physician, how did you—?

Nersessian: I bet we can't afford him after this.

A: I'm not a plant, but I'm just so curious, because I haven't been back with my husband again, to be able to ask you this question. Where did this terrific communication skill come from?

Jacobs: Well, thank you. It just makes sense. If you want to establish a connection with somebody, if you don't have perhaps as much time as you need, why not do something simple like sitting next to him?

Konopasek: That's great, and I think that's a great point. There are simple things to do and it's even more important to do it well now that we have less time. Because a lot of people will say, "Oh, I don't have time to communicate effectively." I would argue that's why you need to communicate effectively.

A: I want to preface my question by saying that I'm one of these people who does everything to stay healthy. I stopped smoking. I eat the right foods. I work out five times a week, etcetera. I have a sister, by the way, who smokes, who has diabetes, who has all of that stuff, and I have a problem discussing this with her. But my question is this: when somebody comes to you who's starting to gain weight or who hasn't stopped smoking, do you feel it's your responsibility, and do you have the courage to tell them, "Hey look, this is what you've got to do." Just from that end—not pushing pills, but just taking care of their bodies.

Jacobs: I will say quickly yes, absolutely. And it pays to ask on a repeated basis. On the other hand, a person who is gaining weight and who knows they're gaining weight doesn't have to be necessarily confronted by somebody saying, "You're obese. You're going to have this problem." Maybe you can say in a gentler way, "I think your blood pressure might come down a little bit, your cholesterol might come down a little bit, if you lose weight." Because sometimes in that situation, the person is so embarrassed by their weight that they won't go see the doctor in the first place. So I think it has to be a clear message, but one that also the person can live with.

Konopasek: I think also our participant who talked about the fact that it also needs to be a conversation and you need to begin by understanding why this is happening is a really important piece.

A: Do they need to go to a psychiatrist?

Konopasek: No, you don't.

Michels: And usually they won't.

Pangaro: But psychiatry and psychology, like the gentleman said before, have contributed enormously to the education of all physicians, surgeons, pediatricians, and internists. If Neoptolemus can say to Philoctetes, "What is it that you want to see happen," then that conversation—what do you want to see happen, what would be a good outcome as far as you're concerned—if you have the training to do that, and the time to do it, and the physical conditioning of your position in the room allows it, then all of those things can come together. But as we see, there are all these different pressures on everybody: on the physician Neoptolemus, and on the patient Philoctetes, the social situation, what the generals in the system want, that you're lucky when all those things converge. But I think there's a growing conversation within the medical community, certainly within the medical education community, on what success would look like ten years from now.

A: I want to thank you for that and for the honesty here today, for the slight mention of the healthcare system, for your frankness. I really didn't expect that and it's very refreshing. We're all on the same team.