Materia Medica

Free Lunch

Daniel Becker, MD

Internal Medicine and Center for Biomedical Ethics and Humanities, University of Virginia School of Medicine, Charlottesville, VA, USA.

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The new chief wants to come and chat and see how the rest of us are doing out here at the research park *cum* clinic. I remind him that in the old days such visits meant free lunch. That would be how the old chief operated, I offered, speaking as the old chief once removed. I press 'send', replying to all, and since this is email, start thinking about what I'd said after I said it. There's more at stake than lunch.

In the old days there were a lot of free lunches. We let the pharmaceutical reps wander around with medication samples, ballpoint pens, and bags of Chinese take-out leaking sweet and sour influence we thought we were impervious to. Times change, money still talks, and conflicts of interest are still worth talking about—not just big Pharma, but personalized primary care versus pay for performance, the industrialization of health care, and the economic survival of public teaching hospitals. The chief isn't coming just to chat; he is coming because the bottom line needs us to see more patients. There are plenty to go around. Primary care general internists are an endangered species, and everyone seems to want one. Supply can't keep up with demand. Speaking as supply, I should know. It may be old fashioned and short-sighted to say so, but it seems like the more new patients we see, the less time we have for our old patients. We're not sure what to do. The time honored solution is to work harder and faster. If the chief brings cake as well as lunch, we'd have our cake and eat it too.

My ethicist colleagues talk about the personal ethic versus the public ethic. Institutions as well as people have a sense of right and wrong, a sense of justice. The hospital wants and needs more new patients—those people waiting back there at the end of the line. The Dean, looking at NIH prospects and decreased state funding for higher education, wants and needs us to see more patients. While I feel honored when my patients ask me to see their parents, colleagues, and neighbors, I wonder where—amidst teaching, administrative, and research obligations in addition to already crowded clinics—I'll find the time or the space. When the tables are turned, when it's me, or my family, or my friend at the end of the line, I expect timely and expert service.

The obvious solution is to figure out how to see patients more efficiently. To make the line shorter we could use more entrances. More gates, so to speak, but instead of more gatekeepers, an unfortunate term that connotes ticket takers, we need modern gatekeeping processes (quick and efficient

pre-registration, on-line personal health histories, downloaded medication lists, automatic preventive care reminders, non-physician staff to help manage information and patients, computer assisted documentation and coding for billing). The problem with efficient new technology is that it doesn't feel efficient at first. We have to install and learn it while doing everything we always did. We also need to process the change, honor tradition, recall the days of the giants. When changing a light-bulb we talk about how nice the old light was—how glowing its reputation. Lucky for us we're doctors and accustomed, since medical school, to being thrown in the deep end and learning quickly not to drown. Moreover, we understand, like Shakespeare, that at we're lucky to be fully engaged in important work: "joy's soul lies in the doing." Unlucky for us, we're also control freaks.

Loss of control, while the work load goes up, fuels burnout. The challenge of work becomes exhausting. The sense of accomplishment no longer renews or recharges. The patient is merely the sum of the parts. As doctors we need quality time with patients. As faculty, we need time to think. As teachers, we need time with students. As leaders, we need time to learn how to lead and time to plan ahead. However, as dedicated and compulsive professionals asked to do more, we're obliged to say yes because we're bad at saying no. Both perfectionist and compulsive, we aim to please, we like—indeed, we need to do – favors, especially if it's the Dean's cousin with abdominal pain after Thanksgiving dinner. When I need a surgeon to drop everything and see my patient with post-prandial abdominal pain, then it helps if I'd recently seen the surgeon's next door neighbor, the one with back pain who has been all over town without relief. Saying yes and being a good colleague amount to being a nice person. However, the new order of health care needs something more robust than *nice*. We need to say "yes" because we mean it, and we need to do favors in a systematic way. Anyone with back pain is the surgeon's neighbor.

There are two kinds of people in the world: those whose backs hurt some of the time and those whose backs hurt all of the time. If your back hurts at the end of a long clinic, you might have something more to offer to patients whose backs hurt at the end of the day—even if, since they're there, they want some help with the sore shoulder too. Thirty minutes of complaints in a 15-minute appointment is a challenge, yet some doctors seem to have all the time their patients need. It helps to pay close attention—to keep mind and heart from wandering, to imagine the circumstance and nature of suffering one appointment at a time. Let's call that presence—an alchemic and authentic mixture of empathy, mindfulness, and narrative. Presence doesn't waste anyone's time. It puts the doctor and patient on the same page of a story that isn't necessarily easy to find or understand. Leaders need to get the story too. Inspired leaders not only have presence, but they also tell compelling stories, stories that the rank and file want to join. The story

might only be a gesture—an invitation or an open door, a thank you note, a hallway conversation—but a gesture that speaks volumes and expresses a commitment to common goals and values.

I remember when the new chief was an intern and I was his ward attending. Every day he'd bring a bag of coffee candy to rounds—individually wrapped for infection control purposes—not just for the doctors and the medical students, but for nurses and ward staff too. This was before the ACGME codified systems based practice as a competence. We'd gather, he'd reward us, and off we'd march to do our best. One of the residents on that team is now one of my practice partners. Between the three of us, we recall three different versions of the sickest and youngest patient on the service, someone who greeted me as the "boss doctor" yet only trusted our collective wisdom. At our meeting today—a lunch meeting in good faith—I am long past being the boss and the new chief is not just the chief. He needs to see more patients too.

We all feel the same growth pains. Change, like life, is unfair at times; at least that's what we teach our children. After a minute or two of moaning and groaning—self-pity spiked with self-mockery—we remind ourselves that we're all in the same boat and our lifeboat looks and performs like a ship. We'll adjust to the newest version of the electronic medical record and look forward to the day when the end of clinic is not festooned with stacked charts, duplicated lab results, faxes from all directions asking for the same orders we signed

yesterday, and sticky labels posted on our computer screens. There will be a day when the end of the afternoon clinic is the end of the day and not the beginning of paperwork. We'll see more patients and use productivity gains to leverage more space and staff in order to see more patients. It's a cycle of growth, but not a vicious cycle. We'll guard the heart of medicine by finding the time to listen at the bedside wherever the bedside happens to be—ward, ICU, ER, clinic, nursing home, hospice, or patient's home. Finding the time means knowing the right moment. Knowledge like that is hard to gain, hard to teach, and essential to what we do. We'll reinvent primary care with our colleagues in general pediatrics, family practice, and nursing. We'll remember to be grateful for the privilege our profession brings—privilege earned but privilege nonetheless. Such gratitude comes in different shapes and sizes—positive gossip, unexpected thanks, a smile, joke, or blessing.

The meeting ends on time because, inevitably, there are patients waiting. As I leave the chief tosses me another sandwich. He brought extra. I'd toss him a piece of coffee candy, but I didn't think that far ahead. Next time.

Corresponding Author: Daniel Becker, MD; Internal Medicine and Center for Biomedical Ethics and Humanities, University of Virginia School of Medicine, Box 800758, Charlottesville, VA 22908, USA (e-mail: dmb2y@virginia.edu).