EDITOR'S NOTE

The Patient-Physician Relationship:
Is Three a Crowd?

Jonathan H. Lin

OPEN AND FRANK COMMUNICATION BETWEEN DOCTORS AND THEIR patients has always been the cornerstone of effective health care delivery. Patients willingly relinquish detailed information about their physical conditions plus personal and family histories to which few people, if any, are ever privy. Physicians are entrusted to use this private knowledge, not for personal gain, but to provide curative and palliative therapies that will unconditionally improve the patient's well-being. These straightforward aims are threatened by the practical difficulties that arise when the competing objectives of other parties (nonphysician and nonpatient) enter the situation.

As described by Joel Schofer1 and Martin Furmanski, societal exigencies can impinge on the relative sanctity of the patient-physician relationship, as during wartimes when government directives have contravened the privacy of the patient-physician relationship. Fortunately, such situations rarely occur. A more urgent factor changing the nature of the patient-physician relationship is the increasing prominence of cost containment in medical practice and the resulting pressure on physicians to see more patients in the same amount of time. As in any other human relationship, trust between the physician and patient requires time to become established. The patient may be initially skeptical of the physician's abilities or intentions and withhold information necessary for a medical diagnosis. The physician may require time to attune to the behavior and speech nuances of a particular patient and appreciate the complete story. How long does it take for effective communication to happen? As Dan Reirden recounts in this issue, years can go by, and the physician may still not be completely aware of the circumstances surrounding a patient's illness. In this age of 15-minute office visits, one can only wonder how much information that could have been useful in treating a patient's condition is left unsaid. Other factors modify the way patients and physicians interact with one another. The growing number of non–English-speaking patients has necessitated introducing multilingual intermediaries between the physician and patient. As Lorna Breen discusses in this issue, information can be readily lost or distorted as the message is translated from one language to another.

The articles in this and future issues of MSJAMA touch on only a few of the challenges faced by physicians in providing personalized and competent health care. As the new academic year begins, medical students would be well advised to keep abreast of the medical implications of changes in the patient population and, perhaps most importantly, the growing dominance of financial incentives in shaping the manner in which physicians interact with their patients.

REFERENCE

What Should I Do If My Patient Does Not Speak English?

Lorna M. Breen, MD, Medical College of Virginia, Richmond

According to the 1990 US Census Bureau, 31.8 million residents, or 14% of the population 5 years old and older, reported speaking a language other than English at home.1 The most common non-English language spoken at home was Spanish (17.3 million) followed by French (1.9 million), German (1.5 million), Chinese (1.3 million), and Italian (1.3 million). Seven states—New Mexico, California, Texas, Hawaii, New York, Arizona, and New Jersey—reported that 20% or more of their residents did not speak English at home.1

Clear communication between the physician and patient is an obvious requisite for effective health care delivery, but how is this best accomplished when English is not the common language? While it may seem that the most logical solution would be to use interpreters whenever possible, many hospitals do not employ professional interpreters. Also, existing interpreters may be underused if physicians and nurses overestimate their own language skills or those of the patient. Some physicians may simply be uncomfortable with the potential for information distortion that can occur through an interpreter.

Another common approach to communicating with patients who do not speak English is to use ad hoc interpreters such as family members, friends, or hospital employees. While this may be convenient, the interpretations may not always be accurate. One study3 showed that between 23% to 52% of words and phrases were incorrectly translated by ad hoc interpreters. A drawback to letting family members interpret is that one sacrifices patient confidentiality. Cultural mores may lead non–English-speaking patients to withhold more information than one might otherwise expect. Friends and family often are not prepared to deal with the complexity required by an interpretation of medical information.

Perhaps the ideal solution to establishing clear channels of communication between physicians and patients would be to recruit multilingual medical personnel in hospitals serving large non–English-speaking populations. The multilingual physician can immediately evaluate a non–English-speaking patient without having to seek out and wait for an appropriate interpreter to arrive, and the fear of mistranslation or shades of meaning being misinterpreted would be removed. Studies have shown that language concordance also leads to increased patient adherence.4

Is it possible for busy medical students to become completely fluent in other languages? Many medical schools now offer foreign language electives. However, data suggest that these courses may not adequately prepare students for interactions with non–English-speaking patients. A study of 8 first-year resident physicians who had completed a 45-hour medical Spanish program at the Stanford University/Kaiser Emergency Medicine residency program concluded that although medical language courses may be a useful adjunct to interpreters, significant errors occur when course participants assume their language proficiency is sufficient.5

Keep in mind that traditional modes of communication, which may be the most readily available, are not the only option. Patient education audiotapes exist in various languages. Also, AT&T has a toll-free Language Line Service, that will connect you with an interpreter in the language of your choice (with up to 140 different languages) 24 hours a day, 7 days a week. Lastly, there has been some movement toward the use of “remote-simultaneous interpretation,” which uses cellular phone technology to link trained interpreters to the people who need them most (Table).

Encounters with non–English-speaking patients are common, especially in metropolitan areas with large immigrant populations. With increased recognition of the difficulties posed by multilingualism as well as the growing number of solutions, we can hope that the treatment of non–English-speaking patients will become less problematic as we enter the 21st century.

Table. Strategies for Communicating With Non–English-Speaking Patients

1. Unless you are thoroughly proficient and fluent in the target language, always use an interpreter.
2. When using an interpreter, address your patients directly, rather than speaking mostly to the interpreter, and allow extra time for the interview.
3. When speaking directly to the patient without an interpreter, speak slowly and carefully, without jargon or idioms and without raising your voice.
4. Repeat when you have not been understood. If something has been said as simply as possible and is still not understood, try repeating the same sentence again; changing words may confuse the patient.
5. Check that you have been understood. Avoid asking questions such as “Do you understand?” or “Is that all right?” as these are likely to be answered by a “yes” whether or not the patient has understood.
6. When encountering difficulties communicating, try using multilingual patient education materials, illustrations, or models.

REFERENCES
Lessons Outside the Lecture Hall

Daniel H. Reirden, MD, University of Connecticut Health Center and Connecticut Children’s Medical Center, Farmington

It seems funny to me now that I was so surprised by his death. Four months later, I seem to be able to regard the events of that week with a little more objectivity, or perhaps a little less denial. I had known William for slightly more than 2 years. In my Student Continuity Practice he came to represent all of the joys and sorrows one can expect to encounter in primary care.

We met on a bright autumn day during my first year in medical school. My preceptor, Dr P, had given me only brief introductory remarks about my patient before William entered the room. I knew that he was infected with the human immunodeficiency virus (HIV), and I knew that he had been through some periods of ill health, but I don't recall having learned much more of his story. In person he was slight of build. Despite a sense of fragility, his spirit was vigorous. William embodied the seemingly contradictory qualities of optimism and realism that are necessary to live with HIV. Still enrolled as a graduate student, he had learned to work on his thesis when his body allowed it and to rest when his body demanded it.

Over that first year, he graciously tolerated my fumbling attempts to take a history and to perform parts of the physical examination. He willingly opened his mouth to show me his thrush. Later, he volunteered to serve as my subject during an assignment to interview a patient with a chronic disease. So that I might better understand what happens after a physician writes a prescription, William typed up a list of the 64 pills he took on a daily basis along with the elaborate dosing schedule.

In addition to taking an enormous number of medications, William came into the university infirmary every day to receive intravenous (IV) antiviral medications through a central catheter. Although constrained by this regimen, he never complained or refused to speak with me when I dropped by, almost weekly, to learn more about his experiences. I remember the day when he described his frustrating attempts to navigate several social service bureaucracies so that he could get some dental work done. As he told me about spending hours of each day on the phone, receiving transferred from person to person, he was forced to interrupt our 45-minute conversation at least 5 times to rush to the restroom, dragging his IV pole behind him, on account of the diarrhea that he lived with regularly. Each time he returned with little more than a sigh or a roll of the eyes by way of complaint, continuing his story where he had left off.

Over the 2 years I knew William, he began to divide his time between two residences: his apartment in town and the infirmary at the university. Eventually, his parents, who were both retired, moved into town to take up residence in an apartment in the same building where he lived—close enough to be helpful and still allow him to retain a semblance of independence. This living situation was just one of the many contradictions and conflicts that accompanied his disease. On one hand, he resented being nearly 40 years old and still reliant on his parents for help; on the other hand, their presence provided a degree of security. It was not uncommon for me to stop by his room at the infirmary to find him dozing in bed, while his parents sat arm-in-arm on the couch watching television. Suddenly, the hospital room became a living room. I wondered on those nights how many homes would be so fortunate as to know that kind of love. On more than one occasion, I found myself faced with the contradictory thought, “How lucky he is.” Not lucky to be ill, but lucky to be surrounded by a sense of unconditional love.

Last autumn, the third since we first met, he was at the infirmary more frequently than he was at home. In September, everyone at the infirmary seemed to breathe a sigh of relief when he was able to go home for the weekend of his 40th birthday party. Friends and family from all over the country arrived to celebrate the occasion. I heard that William was in his glory that weekend. Unfortunately, the glory was short-lived. Within days after the birthday party, he was forced to leave his apartment again. This time he had begun to cough up large amounts of blood. The infirmary wasn't going to be adequate this time: he would be moved to the university hospital.

Dr P had already made a difficult decision by the time I was able to see William in the hospital. In his opinion, this new development was far worse than anything previous. As he looked at William's pale and wasted body, Dr P didn't believe William's observation that “It just doesn't feel like I'm ready to go.” Dr P advised William's parents to call the rest of the family lest they miss their opportunity to say goodbye. The family all rushed to his bedside, but William was right; it wasn't yet time. In several weeks he was strong enough to return to the infirmary, the cause of his bleeding still unexplained. Somehow, he had managed to rally. Intellectually, I understood that this most recent hospitalization changed everything that had gone before. But hadn't he managed to surprise us time and time again?

It was a Tuesday, my clinic day, when he arrived back at the infirmary from the hospital. I decided that I would go upstairs and spend some time with him before I headed home for the day. Sitting up in bed, he looked tired but not as bad as I had feared. William's mother was visiting while he was attempting to eat some dinner, so I sat for a while to chat. No more than a few minutes had passed when William...
uttered a startled sound and I looked over to see him, looking terrified, with a bloodied cup in his hand. I grabbed a pair of gloves and a warm washcloth. This time it looked like the blood was coming from a sore on his tongue, and with a little pressure I was able to stop the bleeding. I breathed a sigh of relief, grateful that things weren't as bad as they had first appeared. I said good night and told William that I would see him next week. I really believed that I would.

But, if I really believed that I would, why couldn’t I shake the sickening feeling in the pit of my stomach? If I really believed that I would, why was I so obsessed with getting back to the infirmary to see him again? It seems so clear now, yet I was truly unprepared for the news of his death when Dr P paged me on Friday morning.

Dr P explained that he had received a phone call from the nurses’ station in the infirmary at noon on Thursday. William was requesting that he come up as soon as possible. When Dr P arrived in the room, William calmly stated that he felt like the time had arrived for him to go. He wanted to know if that would be okay. William then looked at his mother and asked her permission to die. I suspect that granting this permission was the hardest thing this mother had ever done. Soon after, a morphine drip was begun and, as Dr P told me, a most amazing change took place in William. William had always denied that he was in pain; in fact, he rarely complained of anything. Yet when the morphine drip began, a brightness overtook William’s face. Dr P said that it was like watching years of accumulated pain melt away. William spent several hours sharing the company of his family and a few close friends, with whom I felt privileged to be included. People held hands, hugged, prayed, laughed, and cried. Eventually, William felt the need for sleep, so he curled into a fetal position and slept. The friends stayed in his room sharing stories about his life while a brilliant sun set over the gothic buildings outside the infirmary’s windows. As the light of the beautiful autumn day faded, William’s breathing slowed. At 10 that evening, it ceased.

I attended a memorial service held in William’s memory about a month after his death. William had planned this memorial himself as a celebration of his life: he alone had chosen the readings and the music. The service was held in an old Unitarian church on the university campus. In-between the music and the readings, friends had been invited to speak about their relationships with William. A woman with whom he had been friends since second grade had flown in to tell about her lifelong friendship with William. His college roommate shared stories of William the budding actor and intellectual. William, an actor? Another man shared a story about William’s struggle as a pastor to a congregation. William, a pastor? William had found himself at the center of a bitter debate about whether homosexuals should be allowed to function as ordained ministers. As William struggled to find the meaning of his role in this debate, he had continued to minister to his congregation until the time that his illness forced him to leave. Many from that congregation sang in the choir at his memorial service.

I discovered that day that there was a lot I didn’t know about William. As each friend shared his or her story, I found myself smiling through my tears. I had always thought William to be remarkable, but what I didn’t realize was that I had judged him knowing only the smallest sliver of his life. How arrogant it was for me to think that because I had shared intimate knowledge of his illness, I knew the whole man. As a physician one is privileged to gain a certain intimacy with a patient. What I learned that afternoon is that our patients always are so much more than just the person we find sitting across from us in our examination rooms. They are each the sum of a life’s worth of loves and struggles. In caring for each patient, our task demands that we respect the limits our patients place on revealing their lives to us, while never forgetting that often we get only the briefest glimpse of those lives. It is by recognizing that we tend to the person who exists both inside and outside of our encounters with them that we provide our best care.

I think of William often. I find myself missing him when I arrive at my continuity site. It is then that I think about who will be on the schedule that day, and I remember that his name will not be among those on the list. I hesitate to invoke the cliché that our patients are our teachers, but, I’m left with no more appropriate description of what William’s relationship was to me. And he, like all of my great teachers, has left me with knowledge that I will carry with me for my entire life.
Unlicensed Vaccines and Bioweapon Defense in World War II

Martin Furmanski, MD, Newport Beach, Calif

JOEL SCHOFER PRESENTED WELL THE ETHICAL CONTROVERSY surrounding use of unapproved agents for chemical and biological warfare defense in Operation Desert Storm.1 Such dilemmas are not new, however, nor the risks purely ethical or medically theoretical. They occurred several times during World War II, the most dramatic and sobering being the yellow fever vaccine incident of 1942.

In January 1942, immediately after Pearl Harbor, the US military decided to vaccinate all active duty personnel with yellow fever vaccine. This decision was based largely on the fear that an enemy power would launch a strategic biologic attack by releasing a virulent virus in areas that harbored the vector. The area at risk included vital areas of the United States: much of the East, Midwest, and South and southern California. It also included essentially all overseas combat areas: China, the Pacific islands, Australia, India, Burma, southern British, coastal France, the Mediterranean area, and the southern Soviet Union. The army had since January 1941 already addressed possible accidental transmission of the virus from endemic areas by selective vaccination, fumigation, and quarantine.2

Concern regarding biological attack was well founded. From 1932 to 1945 the Imperial Japanese Army undertook a massive and ethically horrific program to develop biological weapons. The United States became aware of this effort, sought intelligence, and took the threat seriously. The FBI investigated repeated overt and covert attempts by Japan to obtain virulent yellow fever virus in 1939.3

In 1942, all military personnel received typhoid, smallpox, and tetanus vaccines, and soldiers who refused vaccination were subject to court-martials—a military legal principle originating in World War I and continuing to this day.4 However, during World War II, a yellow fever vaccine had not yet been licensed for civilian use in the United States and an FDA-approved vaccine would not be available until 1953. The yellow fever vaccine used in early 1942 contained human serum, and despite earlier published reports of unexplained or “homologous serum” jaundice occurring after its use, the perceived urgency of the biological weapon threat propelled this vaccine into use. Unfortunately, many lots were contaminated by the hepatitis B virus. An epidemic of unexplained hepatitis began in March 1942, and yellow fever vaccination was halted on April 15, 1942. Approximately 51,000 military personnel with symptomatic hepatitis were hospitalized, and subsequent serologic investigation of veterans concluded that approximately 330,000 persons had been infected.5

This is the largest point source outbreak of hepatitis B ever recorded. Although chronic hepatitis following yellow fever vaccination was recognized, the vaccinated soldiers have fared surprisingly well: on follow-up they have an unexpectedly low carrier rate and no increase in death from chronic liver disease. They have, however, a small excess in deaths from liver cancer.6

Of course, in 1942 the principles of the Nuremberg Code (1947) had not yet been formulated, nor had the US military officially adopted them as policy (1953).7,8 Although modern codes of medical ethics did not exist to restrain the use of unlicensed vaccines by the military, the tens of thousands of iatrogenic casualties from the yellow fever vaccine experience may well have had a chilling effect on further use of other experimental vaccines.

In fact, in 1944 an erroneous report of Nazi weapons using botulinum toxin was taken seriously by the US government, and in response a crash program produced enough unlicensed botulinum toxoid to immunize the entire D-day assault force. Despite strong recommendation by the US Army Surgeon General to immunize all personnel before the Normandy invasion, the theatre surgeon, responsible directly to Eisenhower, opted to hold the toxoid in stockpile.9 Ironically, during Desert Storm large-scale administration of this toxoid had to await the formal informed consent process.

REFERENCES

Scarecrow

Wyoming seemed another planet
So glacial—almost lunar.
I'd never seen a snowfence till
We rounded the lone mesa—there
The plain was split in miles of
perfect lines
In miles of perfect lines in
midsummer
Deducing “snowfence” was a stretch
I didn’t make as we, bewildered,
Drove on to Laramie.
We drove on to Laramie.
Now another vision of Wyoming
Drifts through my daydreams.
The western Autumn bleakens.
The western Autumn bleakens—
Is that possible, in summer it
was brown.
Now frost crisps sparse grass
And “snowfence” makes more sense.
Snowfence makes more sense
But senseless still that they lashed you
There, left you, native son, to die—
A scarecrow under the endless sky.
A scarecrow under the endless sky—
The Western autumn bleakens
And snowfence makes more sense.
Wyoming seemed another planet
As we drove on to Laramie.

Laurie A. Bankston
Wright State University
College of Medicine
FIRST PLACE

Coma

Tell me again how love
is like a poem taking shape
in the wee hours
when you think me
a sleeping moon,
a night light passing between
open window sills.
Yes, lean over me and say again
how ink is drawn
from stylus to page
by the woo of capillary action,
how the rapid-fire infilling
of tiny spaces in the page
can, for a moment, satisfy
all the tiny longings
in your soul, the little things
we used to say and do.
One last time
touch the palm of my hand
and let your fingers move
like pen strokes—
all fever and felicity.
Let me feel again the dottings,
crossings, commas, periods
before the closing of the sills.

Deron Burton
Johns Hopkins University
School of Medicine
SECOND PLACE

Large Woman, Half

Large woman, half-sitting
wrecked among the creased sheets,
tubes, sharp needles, blue blankets
incurious
Her loose white and rain-gray hair
stripes pillows
She has the preoccupied jelly gaze
of a fish
Under the gown, she has been cracked
down her center
And shut tight again.
There is dried blood
traveling the long barbed seam.
Bent to listen,
there are gusts
Newspaper crackling
against the wire fence of suture
New wine bubbling up
A door banging open into an empty room
Heavy trucks on an unfamiliar stretch
of highway
Branches gnashing the tin roof of a shed
Or birds settling in zoo cages at dusk?
I move the stethoscope again
and again
Again
Pressing
It stamps the warm freckled flesh
Even the fabric murmurs
Explaining
Well, I am new to this
I cannot fully appreciate your
heart sounds.

Alyson Porter
University of New Mexico
School of Medicine
THIRD PLACE

For more information about the William Carlos Williams Poetry Contest for Medical Students, visit the MSJAMA Web site at www.ama-assn.org/msjama.