

White Coat Ceremony

“This above all . . .” Keynote Address

BARRY STIMMEL, M.D.

WHEN I WAS FIRST INVITED TO SPEAK, the instructions given to me by Dr. Smith were (a) be inspirational and (b) be brief. I therefore had to resist the temptation, in the current political climate, of advising you upon starting your first year of medical school to “bring it on” and sit down.

I realize that at this exciting time you are inundated with many facts, and it will not be easy to remember what is said in a setting such as this. Nonetheless, in the hope of promoting retention, I decided to relate a personal experience that describes two aspects of our behavior which, I truly believe, are essential to being a physician—yet are often forgotten, or worse, unconsciously manipulated to make us appear as less than we really are. These aspects are pride and respect.

First, I should state unequivocally that you have several reasons to be proud. It is not easy to be accepted into a medical school—especially a good one—and you are at one of the best. Second, you will be mastering a body of knowledge that will allow you to prevent diseases from occurring and to alleviate pain and suffering. However, it is all too easy for pride to turn into arrogance, manifested as a loss of respect. First a loss of respect for certain diseases, then perhaps a loss of respect for certain patients—and this can literally be deadly. This is not a hypothetical or theoretical danger, but is often recounted when patients describe their contact with some physicians. Most often, it can be seen by simply walking through an emergency

room or clinic and observing the way some physicians relate to patients.

A number of years ago a study looked at students’ attitudes in their first and senior years towards patients with AIDS and those with substance abuse problems (1). The study found that the feelings of first-year students with respect to treating AIDS patients were positive, and that these feelings did not diminish, but even improved slightly in the subsequent four years. But their feelings concerning treating persons with substance abuse problems actually deteriorated, with 78% stating they strongly disliked these patients and would avoid them.

This is not an isolated finding. People in pain often suffer needlessly because of physicians who are not uncaring—but are certain they know better as to when the patient is really in pain. Equally important, we tend to feel that people who do not meet our image of “solid citizens” do not tell us the truth. Numerous studies have documented that patients in underprivileged communities who suffer intense pain receive less medicine and less attention in emergency rooms and clinics than those who are more affluent. In addition to causing unconscionable suffering and distress, the adversarial relationships that often develop between physicians and patients are rationalized by physicians as being related to some inherent lack of worth of the patient rather than to their own behavior. To put it bluntly, these findings have suggested to many that some of these disparities in health care are due to conscious or unconscious racial bias or stereotyping on the part of the physicians (2–4).

Now, let me tell you a story that I hope will stay with you. It covers good and bad aspects of medical care encountered by a patient of mine.

The patient, a woman in my care for a number of years, was in her 40s and suffered from severe hypertension and diabetes. However, she had two other characteristics that put her at risk for not receiving the best of all possible care. First, she was markedly obese, and second, she was African American. One

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Address all correspondence to Barry Stimmel, M.D., Dean for Graduate Medical Education, Professor of Cardiology, Box 1076, Mount Sinai School of Medicine, One East 100th Street, New York, NY 10029; email: barry.stimmel@mssm.edu

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morning at approximately 3 AM, I received a call from her husband, who had been sitting in the emergency room with his wife for quite a long time. Well aware of the system at teaching hospitals, he had brought his wife into the emergency room following a party, as she had become distressed over developing some slurring of her speech. He had finally called me because, although the emergency room was not particularly busy, after being seen by the triage nurse, his wife had been seen by no one over the ensuing several hours. I asked to speak to the resident on call, who informed me that the triage nurse had screened the woman and felt that, since she had been out drinking and had perhaps had a little too much, they would wait for her to “settle down,” so that a complete medical history and physical examination could be undertaken. I rapidly informed the resident that the woman did not consume alcohol on a regular basis and had brittle hypertension and diabetes. I insisted that they take her blood pressure and determine her blood glucose immediately, and call me back with the results. Unfortunately, I fell asleep and awakened within the hour realizing I had never received a phone call. I immediately went to the emergency room, just in time to see the resident running towards me, looking ashen and apologizing for what had happened. Despite knowing her history, since her arm was too large for the routine blood pressure cuff, both the nurse and the resident—certain of the validity of their initial impressions—became distracted and never bothered to obtain a larger cuff, until my patient seized and was then found to have a blood pressure of 220/170.

Unfortunately, she suffered a stroke. Upon seeing her and her husband that morning, I told her that the care she had received was far from adequate and that she certainly had the opportunity, if she wished, to seek legal redress. She replied that I had been caring for her for the past six years and that she had no desire to cause me or the hospital any problems. She just wanted to get better and to continue to have me provide her care. I reassured her that this would not be a problem. She recovered—almost fully—after spending a month in a rehabilitation facility prior to seeing me again in the office.

Now for part two: When she came to my office, she was furious. I asked her what was wrong, and she told me she had just received a letter from an attorney who had reviewed her entire chart and told her she could receive several million dollars without ever going to trial, due to the care that had been rendered. I reminded her that, in fact, I had told her the care was far from adequate. She replied, “That’s not the point, Dr. Stimmel. I want to know how this person got hold of my record. Doesn’t confidentiality apply to patients anymore?”

This, of course, was a very good question. I subsequently contacted the hospital legal staff, which in turn contacted the District Attorney’s Office, which had a police detective impersonate my patient and meet with the attorney in question.

Let me pause for a moment to explain to you what happens when an adverse event occurs in any hospital. The records are always pulled and reviewed by an in-hospital committee to make certain that systems are put in place so that such an event does not recur. Then the chart is forwarded to the main insurance agency.

As it turns out an individual at the insurance agency was taking “gold standard” cases of less-than-adequate care and farming them out to various attorneys in the city, including those at several prestigious law firms. Discover of this situation immediately initiated a criminal inquiry and, subsequently, a civil suit that forced a large number of law firms to return millions of dollars. The attorney responsible for releasing the records ultimately committed suicide.

Now, to the point of the story: This woman’s care was less than adequate because of misjudgments on the part of nurses and physicians—misjudgments based on arrogance and a lack of respect. Yet maintaining a strong doctor-patient relationship resulted in identifying and stopping illegal behavior rather than in a lawsuit against the hospital. Finally and most important, I am telling this story because of the letter that I subsequently received from this woman. I have—as I am sure all of you will in the future—received honors, awards, and certificates. None of these is on my wall. However, this letter is one that I did frame and hang. It reads:

“Dear Dr. Stimmel: Just a note to say thank you for many things. First, for being the ‘doc’ that I have complete faith and trust in, in his treatment and diagnosis. Second, for always treating me as a human being, no matter what my financial situation was at that time. Third, for being there at all times and my knowing that you were just a telephone call away.”

My one wish is that all of you will receive many such letters. This is really what medicine is all about.

As you will be doing today, those entering medicine take an oath of service. Thanks to the generosity of Dr. Gold, today’s White Coat Ceremony is replicated across the country. This, of course, is wonderful. However, if there were to be only one required remembrance for a physician, I would ask you to recall the words written not by a physician but by a man who truly understood human behavior. These are the words spoken by Polonius to Laertes through the pen of William Shakespeare: “This

above all, to thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man (5).”

I would ask that you all be true to yourselves, taking pride in the knowledge that you will acquire in the next four years, while retaining the humility and empathy essential to being a physician.

Congratulations! You are embarking on a wonderful journey. I envy you.

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