

## Professionalism: Definition and Qualities

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[Please recall my lengthy disclaimer from Part 1 of this series.]

Moses Maimonides (1135-1206 AD) was a Jewish rabbi, philosopher and physician who studied and practiced in northern Africa. The ***Oath of Maimonides*** expresses his attitude towards our shared profession, that is still applicable to the bedside in a modern ICU:

**"The eternal providence has appointed me to watch over the life and health of Thy creatures.**

**May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.**

**May I never see in the patient anything but a fellow creature in pain.**

**Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today.**

**Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling."**

I want to try to define professionalism, then call-out distinct qualities required to do the job right, as enumerated by Maimonides.

**Definition of professionalism for a doctor: A good doctor *can be trusted to* always place his/her individual patient's best interest first, with ability, good judgment, and a caring attitude.**

Maimonides points out, first and last, that it is a privilege to be a doctor –not just a career (the word career implies that our main purpose is to make a living for ourselves). Being a doctor is a sacred vocation. Our profession is first and foremost one of being a servant to others, not to ourselves. I personally can't reliably maintain this attitude every minute of the day, but I try to remember it as often as I can. In addition to this proper attitude, Maimonides describes commitment, capacity, compassion and humility, which we will discuss shortly. But let's start with "attitude" - just as Maimonides did.

I once very briefly took care of a 57 year old woman with a past medical history of short bowel syndrome, dependent on intravenous feeding. She had acutely developed *Klebsiella pneumoniae* sepsis of unclear origin and acute renal failure. She was receiving antibiotics, stress-dose steroids and dialysis. During her hospital course, she developed belly pain, and a CT showed pneumatosis intestinalis. The surgeon initially recommended conservative medical care, but after 72 hours, her condition deteriorated and he decided to operate. I saw her in the early afternoon on that day, just before the operating room technicians arrived to take her down to the OR. By this point, the proper course of action was already decided, and nothing I was likely to find on physical examination was likely to change it. So I looked her over briefly - put my stethoscope on her chest without listening very carefully - already thinking of the list of other patients I had left to see that afternoon. But as I straightened and prepared to leave her room, she told me that she was scared she was going to die.

Fortunately for me, I wasn't terribly inpatient that day. My work list wasn't too long. I decided to mentally put my work aside\*, and spend a little time with her [in retrospect, this thought that it was not "my work" to spend some time talking

with this patient was obviously incorrect]. I brought a chair into the room and sat at her bedside. She told me some things about her life that I previously had no idea about – personal goals that her illness had prevented her from fulfilling. Now she felt she might never have another chance. I actually believed that she would come through the surgery OK. I listened, and was able to comfort her a little. We ended up holding hands and saying a prayer together. The transport personal showed up to take her to the OR, interrupting us a little, but we had had a nice quiet moment together. I told her I would check in on her after her surgery. But she developed intraoperative complications and died in the OR, never again regaining consciousness.

This surprised and deflated me when I was notified shortly thereafter. Then it struck me more deeply that I was the last person on earth to talk with her before she died - perhaps with the exception of the anesthesiologist asking her to count backwards from 100. What would this patient's sister, or best friend have given to trade places with me in that quiet moment we had together? The privilege that this represents is astounding. Whether you believe in God or providence, there was a *reason* that we are given such opportunities that goes way beyond simply making a living. The great opportunities we share demand our commitment.

**Commitment: being willing to make sacrifices in an unswerving effort to achieve a single goal.** Our *primary* goal, as taught to me by my friend and mentor, Tom Bajo, is to get the patient and their family through their illness with as little disability and suffering as possible. This sounds very straightforward on paper, but it can be hard to keep your eye on the ball in complicated clinical situations.

Consider the following story:

A 54-year-old patient who was admitted to the hospital with a chief complaint of “I feel terrible”. He underwent a liver transplant 12 months before, but was suffering transplant rejection despite treatment with tacrolimus and rapamune - drugs that had inflicted

significant side effects. Over these past 2 months he suffered progressive severe liver failure, and had been turned-down for a salvage transplant. He had suffered recurrent episodes of acute renal failure, severe nosebleeds, unremitting diarrhea, encephalopathy, and depression.

In his admission history, his symptoms included nausea, anorexia, muscle pain, headaches, weakness, belly ache, recurrent nose bleeds, general debilitation and vomiting-up bile and all his medications. He had been admitted 3 times in the prior 2 months for similar complaints, only going home for a few days in between admissions.

At the time of his physical examination it was noted that he was cachectic, somnolent and deeply jaundiced. When the nurses tried to place a Foley catheter, the patient refused – the nurse quoted him in the chart as despairing: “I’ve been through so much.”

The patient expressed his wish to be made DNR to multiple physicians, and an order to that effect was written. But he was incredibly debilitated, and his ability to defend his decision was weak. A few hours later, a specialist spoke with him and rescinded the DNR order.

The primary managing physicians made the following assessment of the patient:

1. pancytopenia secondary to liver failure
2. volume depletion causing acute renal failure
3. hypercalcemia partially related to immobility
4. rhinorrhea, possibly secondary to CSF leak

(this later diagnosis seems odd, but was influenced by the patient’s complaint of a persistent runny nose after treatment of the patient by an ENT doc who was consulted to treat his nosebleeds – it was hypothesized that the treatment might have been complicated by a fracture of the patient’s cribriform plate, resulting in a cerebral spinal fluid leak)

I want to pause the story here for a moment to consider this assessment. It strikes me that it is almost unrecognizable in relation to the patient lying in the hospital bed. The assessment that lays more closely to the truth, and that would have better guided appropriate therapy is:

1. *the patient is dying.*
2. *the patient is suffering.*

The following management was ordered:

CT scan of brain and sinuses, spinal tap, neurosurgery consultation, ENT consultation, cefepime and vancomycin antibiotics, lab tests including TSH, free T4, iPTH, 1-25 vitamin D, 25-hydroxy vitamin D, SPEP, UPEP, Beta-2 transferrin of nasal secretions, Fe, TIBC, ferritin, methylmalonic acid level, homocystiene and fractionated bilirubin (looking for hemolysis).

I can't say what thoughts were in other people's minds, but their actions speak about the goals they were committed to achieving. Some appeared to be committed to merely keeping the patient alive. Some appeared to be committed to making obscure diagnoses that were highly unlikely to bring any relief to the patient. Some who privately felt the reversal of the DNR was wrong, seemed committed to preserving their working relationship with the specialist, who is a highly respected physician. Many doctors felt that what the patient really needed was comfort care, but nobody committed to that as their primary goal.

The patient suddenly lost consciousness, was found to have suffered a massive intracranial hemorrhage, and was transferred to the ICU – astoundingly for "*a higher level of care*"! By this, they meant more intervention – possibly endotracheal intubation. But now, my partner Jennie assumed authority for his care, and she immediately re-established DNR status and initiated comfort care.

If you are going to commit yourself to a single goal, pick the one that is achievable and most important to your patient, then chase it to the best of your

ability with a caring attitude.

There are many *false* primary goals in medicine – not necessarily bad goals, but distractions from the best goal. We all need to de-prioritize these in order to be better doctors. In part 3 of this series, I will review some of these (likely getting myself in further trouble).