

Affability: Desirable Physician Attribute, or Synonym for Mediocrity? — a Case Study

Robert A. Peraino, M.D.

Changes promulgated by concern for the cost of medical care are exerting a subliminal influence on physicians to become organization and population-centered, rather than patient-centered as required by our professional ethic. My story illustrates the potential for dire consequences if we do not take action to resist this trend.

I am a physician with almost 40 years of experience, board certified and recertified in internal medicine, critical care medicine, and nephrology. I was recently told that I would not be hired for a permanent hospitalist position because I lacked affability.

I have more than 10 years' experience working as a hospitalist, and had worked in this particular institution on a temporary basis for 20 months. I was told that I was a very competent internist and hospitalist, an efficient worker, and an excellent teacher—by the same physician manager who told me I was not “affable.”

When I started the job I was one of six locum tenens physicians. When the job ended I was the last locum to leave. I was praised by both nursing and medical staff and repeatedly asked whether I was staying on permanently. I received at least six patient thank-you letters addressed to the hospital. To be fair, I should mention that I also received two written complaints.

A Case Report

My alleged deficiency, lack of affability, was gleaned from the following incident:

An elderly woman was admitted to hospital because of stroke symptoms and objective neurological deficits. Her systolic blood pressure was consistently less than 120, and her heart rate was 50 to 60 beats per minute at all times. Her symptoms waxed and waned repeatedly. The usual stroke evaluation did not reveal a specific treatable or correctable cause that would stop her recurring symptoms. I decided to stop her medication and allow her heart rate and systolic blood pressure to rise. (Elderly patients tend to lose weight as the years pass and may not require the same medication that was needed to control their disease one or two decades earlier.)

Without medication, the patient's fluctuating neurological symptoms and signs resolved. She was to be discharged on a combination of dipyridamole and aspirin only. The patient and her daughter, who had her healthcare power of attorney, were both very pleased with the outcome. The nursing unit manager and a case manager, also an R.N., objected to discharging the patient without the same medication she was taking on admission. As the excellent teacher I was said to be, I explained my rationale to them. But that was not good enough.

Both nurses told the patient and her daughter that the same medication prescribed prior to admission should be resumed. Bewildered by the nurses' comments, I was forced to tell her to disregard the nurses' comments and focus on her mother's improvement, and that the changes I made led to the improvement. She wrote a thank-you note to the hospital about the care I provided.

In an effort to override my order to permanently stop the medication, both nurses proceeded to ask each hospitalist they encountered on the unit (my colleagues) to override my order and re-order the patient's admission medication. Other personnel, patients in the hallway, and visitors on the unit were privy to their pleas. Each hospitalist refused their request and advised them to talk with me.

When I became aware of the nurses' activity, I reprimanded them in view of others in the vicinity. Since they seemed to have no qualms about undermining confidence in my abilities by trying to override my decision in full view of others, I saw no reason not to do the same. They immediately sought privacy to continue their plea to me. The careful explanation I provided to them earlier was repeated. I filed a formal complaint with the hospitalist program director. Subsequently I was interviewed in person by the hospitalist program director and the physician manager who would label me as lacking affability.

In my view, the matter was not one of being affable or not. It was a matter of unprofessional conduct by the nurses to try to have my plan of care overturned by another physician, based solely on their opinion. Their interference in my plan of care represented an immediate threat to the well-being of that patient—and to her and her daughter's confidence in my ability, as well as the confidence of any other personnel, patient, or visitor who overheard their pleas. Because they had not listened to my explanation when they first expressed their opinion, it was appropriate for me to act forcefully to get them to stop their repeated solicitation to have other physicians interfere.

The Non-Affable Physician

The care of a hospitalized patient with multiple, active comorbidities and a long list of prescribed medication requires intense focus, and careful consideration of the diagnostic and therapeutic plan of care that is individualized for that person.¹ Many patients are hospitalized precisely because they had been treated with the population-based recommendations that government bureaucrats take as gospel, with disregard for individual preferences. The multiplicity of co-morbid conditions and their treatment increase the risk of side effects and clinical illness. The threat of non-payment adds substantial weight to coerce compliance with their “guidelines” for care.

I am an intense and highly focused clinician. That is why I make very few mistakes and make the diagnosis when others cannot. Patients and their loved ones seem to appreciate that focus. When it comes to patients and their loved ones, I seem to be even more affable than most. So, why the difference in the eyes of physician and nursing management?

In contrast, except for one physician and one physician assistant, my hospitalist colleagues didn't seem to have an interest in learning. They tended to treat systems and symptoms rather than patients. They frequently became bewildered by the array of physical findings and diagnostic test results. Instead of taking time to think about the patient's dilemma, search the literature, and ask colleagues for help, they call in more and more consultants and order more and more tests. These are conscientious physicians, applying what they were taught and blindly accepting of the subtle coercion influencing their practice, as expressed by the physician manager who labeled me as lacking affability.

Each morning as we received report from the night physician, my colleagues would complain about difficult patients who remained undiagnosed or had not responded to the prescribed treatment. Complaints about issues related to nursing care were also a morning routine, in particular the lack of urine specimen acquisition for culture before antibiotics were given.

In an effort to promote a learning environment, I purchased an erasable marker board and hung it in the hospitalist office. I invited my colleagues to add cases to the board that we could all discuss. I started the process by writing in three cases, and the one of my colleagues who was also interested in learning followed suit. After discovering the board, the hospitalist program director scheduled time for all of us to discuss the issues written on it. That was the first and only time a formal learning session occurred among us. No one else used the board to take advantage of team learning and to assess different perspectives on difficult and challenging issues.

I do not badger or demean nursing or other personnel. The current climate in which all of us practice is difficult enough. I believe in mutual respect, and I hope my work habits and intensity promote the desire in others to improve what they do. Some take advantage of the implied challenge to do better—but very, very few do.

Instead, I am labeled as someone who lacks affability.

Physicians who allegedly lack affability, such as I, are a dying breed—or so said the physician manager who labeled me. I believe he is right. Affability—concern for population health as opposed to individual patient care—is now tied to one's paycheck. The new and evolving concept of a medical home for each patient will deal the final blow to competition based upon quality and patient-centeredness. Making it extremely difficult to change one's medical home sets the scene for the end of the non-affable physician.

I asked the physician manager whether my other qualities—clinical acumen, efficient work ethic, and teaching—would be more valuable to the organization than affability. His answer: "No." I pointed out that employers have been willing to concentrate on the employee's assets and help with overcoming deficiencies. Would that be possible with me? His answer: "No. That's old-hat."

Finally, he asked me whether I had been aware of my lack of affability before our meeting, from prior experiences. I answered "Yes." I wanted to say, "Yes, I have always been interested in improvement. Seeking excellence is a trait I learned from my father, a civil engineer. I am not and never have been interested in mediocrity, and therefore lack affability under your definition." But I didn't.

Affability versus Excellence

Hospitals and other medical institutions may advertise excellence—but they accept mediocrity. In fact, it appears from my case that to be affable means one cannot be other than mediocre. To criticize, in the effort to motivate staff to become more patient-centered, apparently means to lack affability, at least according to the physician manager's definition.

Mediocrity allows the institution to dictate processes of care. Health care management gurus make repeated reference to the corporate model of quality improvement—to allow line workers to make changes and thus take ownership of the outcome of their labor. Their pronouncement amounts to lip service. Medical institutions impose changes on the medical staff over any objection. These are usually dictated by authority, accompanied by the threat of non-payment or other sanction for failure to comply. Medical staff must go through myriad committees to effect change within a hospital. The daunting task of raising the specter of change frustrates many, who give up and tolerate the status quo, complaining only to their spouses and others at cocktail parties. Individual physician initiative to solve a recurring problem permanently by direct communication with others directly affected—the so-called health care team members—is frowned upon. Attempting to do this shows a lack of affability.

The expanding intrusion of government into medicine also favors the identification and re-acculturation of those who violate the affability standard. Expanding affability—i.e., mediocrity—is consonant with controlling medical costs. At least, that is the bureaucratic logic. The endless input of management-sponsored group-think that requires yet another round of committee review and endorsement discourages innovation. Innovation by physicians is believed a priori to be synonymous with increased cost. The obvious example: Getting patients with like conditions into government-sanctioned, standardized care is believed to minimize unpredictable expenses due to individuality (patient-centeredness) and paves the way for implicit rationing—which can be blamed on those non-affable physicians. The truth is the exact opposite. Individual patient-centered care actually decreases cost.

From the patients' perspective, choosing affability above competence, character, professionalism, teaching ability, and work ethic amounts to imposing a quality of care that educated consumers of health care will decry. (Note that affability is defined by the manager; I have never been accused of lacking affability by a patient.) The experience of the seasoned clinician, rejected for lack of affability, cannot be tapped by newer physicians and those with little work history in the care of complicated, acutely ill patients. Indirectly, their patients are denied that experience and may therefore suffer from more and more sophisticated tests that carry an escalating risk of harm; more treatments that carry risk, especially polypharmacy; longer hospital stays; more debilitation; and more isolation. Most of the hospitalists hired by the hospital in this example had just finished residency, or had practiced office-based family medicine for fewer than 10 years, and thus had little experience managing elderly patients over a long term.

Needed: More Non-Affable Physicians

Most of the time I will bend over backward to help, and might then be considered affable. When improvement for the betterment of patient care is required, however, affability may just promote mediocrity. As the circumstance may dictate, criticism to promote a change from negative to positive behavior cannot be done

affably. To do so would add an inappropriate air of pleasantry to a serious situation. My case clearly illustrates this point.

While some physicians and other direct care providers may feel threatened by those who strive for excellence, there are many who chafe at forced mediocrity. They want permission to be non-affable. Just listen to their conversations in the cafeteria, lounge, or break room in almost every medical institution in the country.

The expanding movement to promote patient-centered care will increase the number of non-affable offenders. As our numbers rise, one-size-fits-all health care will go the way of other really bad ideas such as the HMO movement.

Given a choice, patients are likely to be on the side of the non-affable doctor. The affable collectivist manager represents a move backwards, a return to medical paternalism. Now that is "old-hat."

Robert A. Peraino, M.D., is a hospitalist and the principal with Medrap Clinical Support Services, PLLC. His main interests, in addition to providing better care through continuous personal learning, are physician-patient communication, patient safety, and medical errors. His website is patientcenteredcare.net. Comments are invited at medrap@roadrunner.com.

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