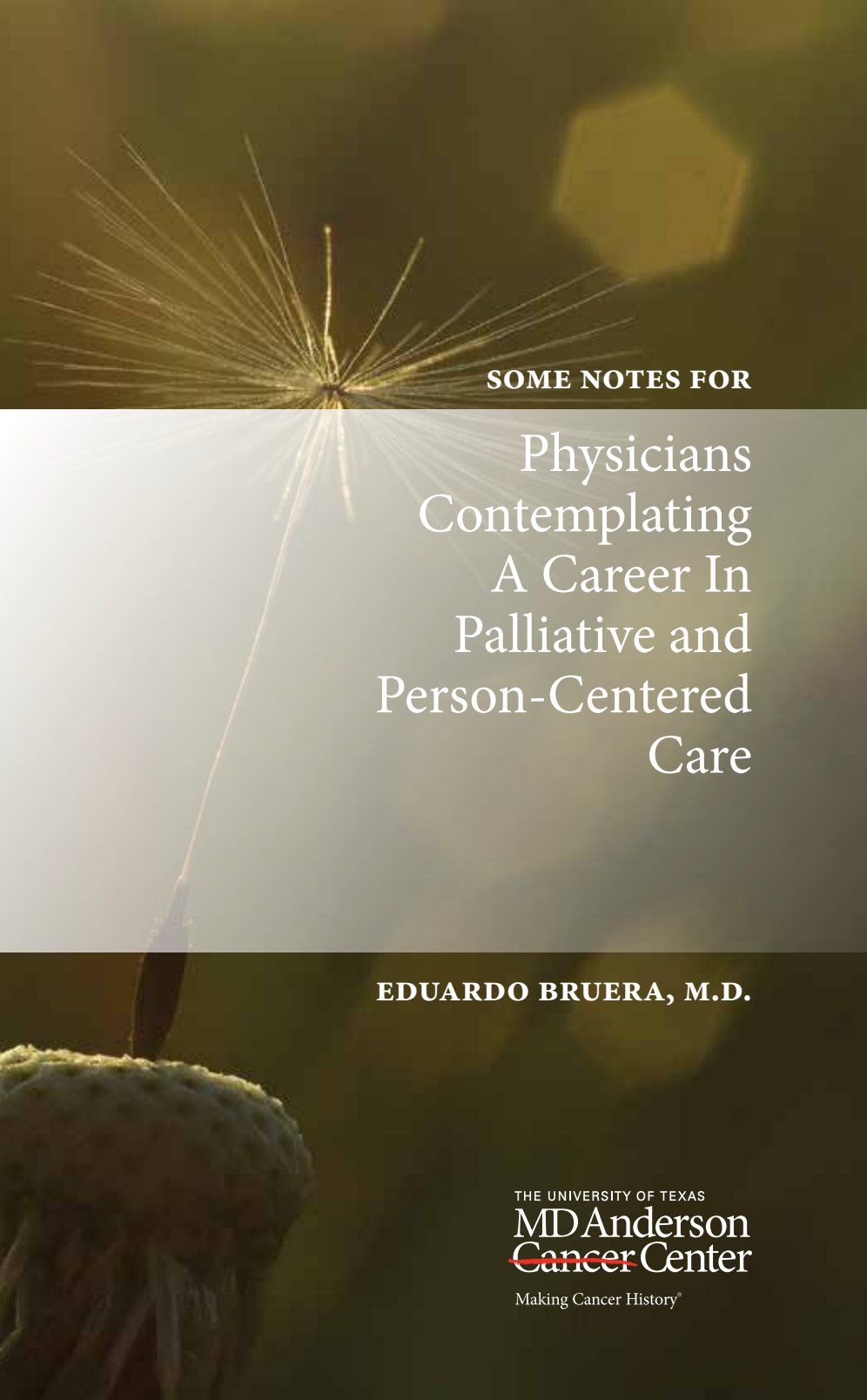

SOME NOTES FOR

Physicians Contemplating A Career In Palliative and Person-Centered Care

EDUARDO BRUERA, M.D.

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

DEDICATION

This book is dedicated to all of the junior physicians I trained and mentored throughout my career. Your contagious energy, hope, idealism, and optimism gave meaning to my daily work.

ACKNOWLEDGEMENT

To Carlos Martinez for his help with the typing and preparation of the graphs for this manuscript, and to Jessica Brown, PhD for her wonderful editing of this book.

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1. INTRODUCTION

During my years as an academic physician I have worked in a variety of structures with different teams and for different bosses. I have received mandatory education and training on clinical, research, teaching, and administrative aspects of medicine.

While most of these educational experiences were useful, over the years I started picking up some extra information and sharing it with junior colleagues and fellows.

As a way of celebrating my 40th anniversary after medical school graduation (Where did the time go?), I finally decided to summarize some of those tips in these notes.

I have published many medical books and more than 1,000 peer-reviewed papers. I greatly value the peer-review process and scientific papers. However, some of the most valuable learnings from my career did not come from my medical readings or my research, but rather from the observation of colleagues in different roles within different healthcare systems, conversations with mentors and colleagues, my own medical practice with patients and families, non-medical books, and career decisions (successful, and especially the unsuccessful ones).

This short book is unapologetically colloquial and there are no references (I found this style the most difficult part of the book since I have never done it before!). As the title indicates, this is

not a "how to" book. I have included mostly chapters I would have loved to be able to read at the early stages of my career, and are still largely not available in textbooks and congresses in our field. This is not a clinical book. I have previously published textbooks and handbooks on multiple aspects of palliative medicine. This book is also not a memoir. I have found those frequently inaccurate and a bit boring to read. This book is short for 3 main reasons: 1) As a junior physician you are busy enough with work and family, and have no time for lengthy rambling books; 2) When a concept is well understood it can and should be described in a few carefully crafted paragraphs; 3) I don't have that much to write about.

My hope is that these notes will help junior physicians entering the field of palliative medicine, where I have spent all my professional life. As is the case for all jobs, it has not always been easy or happy, but palliative care has given great meaning to all aspects of my professional life.

These notes may help physicians from other specialties and other healthcare professionals, but I don't know those fields very well and palliative care is my world and my professional family.

2. WHY PALLIATIVE CARE?

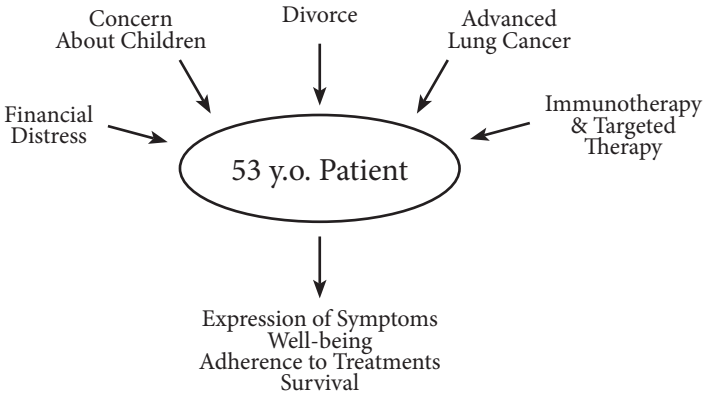
All physicians receive intensive education and training on the diagnosis, treatment, and prognosis of multiple diseases. New diagnostic and therapeutic advances can help patients live longer and better lives.

Some physicians, while impressed with developments in the management of diseases, are more interested in the person who suffers from those diseases. How much physical, emotional, spiritual, and financial suffering are they experiencing? How can the physician alleviate this suffering? How can the physician support the patient's significant others who are also suffering?

Palliative care is probably the best career choice for these physicians.

I discovered I was one of these physicians during my medical oncology training. Most of my colleagues were fascinated by laboratory values, imaging, and objective tumor response. I was much more interested in *subjective,* or *softer,* outcomes in my patients that we were largely not measuring at that time.

A number of other factors can influence how a patient experiences their diagnosis and treatment. The following figure shows how the symptoms, well-being, and even *hard* medical outcomes of the patient can be influenced by multiple factors other than disease stage and treatment effects.

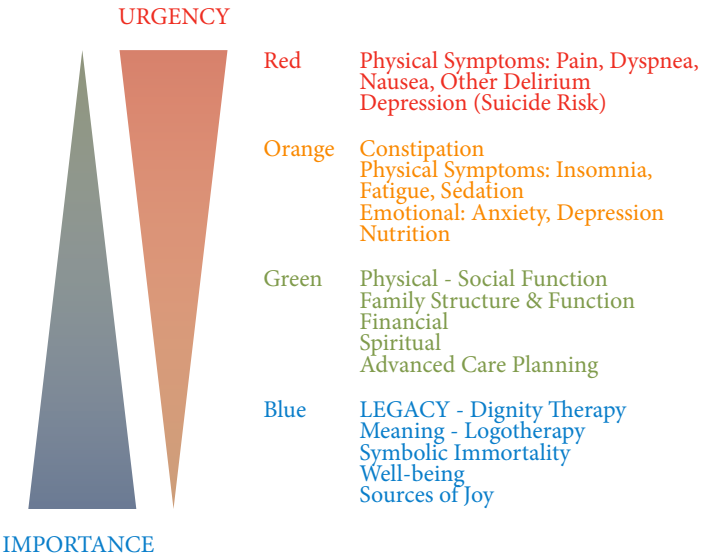


Cancer and other chronic incurable diseases can result in quite variable levels of physical suffering. A two-inch lung cancer in the right upper lobe can result in progressive fatigue, hypoactive delirium, and death. The same tumor mass, if located one inch higher, can result in excruciating pain due to brachial plexopathy or massive hemoptysis caused by the invasion of large blood vessels.

Psychosocial and family factors can also have a major impact on the way a patient and their family experience and cope with the disease. A patient with advanced lung cancer with middle or upper class socioeconomic status and good family support is likely to be able to remain comfortably at home for most of their remaining time. A patient with exactly the same type of cancer with low socioeconomic status and/or very limited family is likely to have a much more difficult experience and much more limited access to care.

Palliative care physicians are experts at looking for all of these contributors to suffering, and for helping patients and family members feel safer.

The following figure shows some of the multiple dimensions of palliative care interventions.



The red and orange dimensions are mainly biomedical; referring colleagues understand these dimensions the best and they are relatively easy for you to feel comfortable with. Understanding of these dimensions is also critical to be able to give the patient the level of basic comfort required to move on to the green and blue areas, which are the most complex and important for the majority of patients and families. Occasionally, a patient will be referred with minimal, or no, actionable red or orange problems. An inexperienced palliative care physician will consider this referral as *too early.* A mature specialist will see this referral as a wonderful opportunity to move directly to the blue and green dimensions of palliative care. Understanding of the blue and green dimensions requires years of bedside learning with experts. Since you will spend most of your career seeing patients and families facing death, it is critical that you make this investment of time and effort.

In the last decade more than 30 books have been published on death and dying by patients, relatives, and health professionals. These books are very useful for those who do not practice palliative

care, but will add very little to your already-acquired technical and bedside learning. On the other hand, you may find, as I did, that the classics describe the human experience of illness and death in great depth. Borges's *The Immortal,* Tolstoy's *The Death of Ivan Ilyich,* and CS Lewis's *Grief Observed* are three books that I found particularly helpful. Shakespeare, Kafka, and St. Thomas Aquinas have also written wonderfully about death. If you are short in time you can Google their most meaningful paragraphs.

THE GOALS OF PALLIATIVE CARE

> ***"There is a general rule and I have seen great physicians acting on it, that the physician should not treat the disease but the patient who is suffering from it."***[1]
>
> **Maimonides (1135 – 1204)**

Maimonides, a physician who lived between 1135 and 1204, is credited with the following statement: "There is a general rule and I have seen great physicians acting on it, that the physician should not treat the disease but the patient who is suffering from it."[1]

Unfortunately, medical school deans, hospital presidents, and health insurance executives have not yet succeeded at making the patient a priority. However, mainly due to bottom-up pressure, major improvements are starting to happen.

It is important to remind our leaders that all patients, as well as all caregivers, medical school deans, and hospital executives will ultimately die.

Very few (if any) other health events are 100% unavoidable and capable of creating so much suffering. Therefore, it is critical to the

1 Jonsen AR. *A Short History of Medical Ethics.* New York, New York: Oxford University Press; 2000.

mission of major hospitals, healthcare networks, and universities to dedicate structures and processes for palliative care that are at least the same size of all other medical disciplines.

SUFFERING IS UNAVOIDABLE

The end of our lives frequently involves considerable physical and emotional distress. It is impossible to make a death from cancer, congestive heart failure, or COPD an enjoyable time for a patient and their loved ones. Inexperienced palliative care physicians can easily burn out if they attempt to *eradicate suffering.* It is impossible to completely eliminate physical and emotional distress, since suffering near the end of our lives is embedded in the DNA of all species. We have the ethical obligation to acknowledge this and avoid statements of total success that mislead patients, the public, and burn out colleagues.

On the other hand, there is a large amount of unnecessary suffering that can be dramatically alleviated with impeccable assessment and management of the most common physical symptoms, assessment and management of psychosocial distress, functional support, spiritual support, family care, and appropriate communication about advanced care planning and end of life.

Palliative medicine specialists working within interdisciplinary palliative care teams can achieve great levels of professional satisfaction, and can make a major contribution to both the clinical well-being of patients and families and the palliative medicine body of knowledge.

An incurable progressive disease causes multiple physical and emotional symptoms, along with the inability to work, drive, and participate in many social functions. When healthy adults are asked about being in such situations, more than two-thirds say that a life like that would be meaningless and they would prefer to die. However, very few of your patients will consistently want to shelter

their lives; in places where physician-assisted suicide and euthanasia are widely available, only a small number of patients who ask for such interventions ever use them. Two years ago these patients were healthy members of the population, and at that time they considered their current situation unbearable. You will find over time that patients find meaning and value in aspects of life they found less important when they were healthy: a visit of a loved one, music, a prayer, a bird, a sunset, or a small act of kindness (more on these in the next chapter). Some of your most important interventions are to help these patients and families to identify meaningful activities, and to encourage them to take advantage of them. Since you are not in your patient's situation there is a high risk of underestimating their quality of life and adopting a nihilistic approach to care. By being present and supportive you will be able to learn how your patients see their own quality of life and ways to better serve them.

In the following chapters I will summarize some of the aspects of this practice to pay attention to, and also ones to be wary of.

3. RELATING TO PATIENTS AND FAMILIES

"To cure sometimes, to alleviate frequently, to comfort always."

Unknown, 15th Century

This is not a clinical book. I have edited and written many textbooks and handbooks on different aspects of palliative medicine, and if you want my biased opinion you will find those helpful. However, in this chapter I would like to mention some practical ways in which you might improve the way you relate to patients and families.

You will spend all your professional life relating to patients with physical, psychosocial, spiritual, and financial suffering, along with family members in distress.

Some people, such as my wife Marisa and Dr. Akhila Reddy, have an extraordinary natural talent to rapidly establish nurturing relationships. The rest of us need to work on it to get it right. The efforts you make to improve your communication and empathy skills will greatly help your career progress and clinical outcomes.

There is now strong evidence that many clinical outcomes don't only depend on the appropriate diagnosis and treatment. The physician's ability to develop a trusting, empathetic relationship will influence the patient's adherence and response to multiple treatments, along with the patient and family's comfort.

In palliative care, impeccable attention to details is particularly important when establishing a therapeutic relationship.

> ***"No human interaction is neutral. It is either healing or wounding."***
>
> **Dr. Balfour Mount**

Balfour Mount, who coined the name "Palliative Care," said: "No human interaction is neutral. It is either healing or wounding." This advice has greatly helped me throughout my professional practice and also in life. Suffering makes us particularly aware of small gestures of kindness (or unkindness).

There are some practical kindness measures you can adopt to increase the healing power of your medical encounters.

1. **Sit when you visit a patient.**
   The famous Spanish physician, Gregorio de Marañón, used to say that "the best medical instrument is the chair."

   We have done multiple research studies, two of them randomized, double-blind controlled trials, and found that patients blindly perceive a doctor who sits during a medical encounter as more compassionate, would prefer them as their doctor, and even estimate that the sitting doctor spent more time with them! Since most physicians do not sit during a medical encounter you will have a great strategic advantage in sitting. I always carry a portable chair with me to my inpatient and home visits.

"The best medical instrument is the chair."

Gregorio de Marañón

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2. **Always examine the patient.**
   In times of decreasing length of medical encounters and highly-available imaging technologies and laboratory tests, many physicians are abandoning the practice of regularly examining their patients. We have asked a large number of patients about this and have learned that they greatly value a medical exam each time they are seen by their doctor. They give it a value at the pragmatic level (my doctor may learn information that is useful for my care), and also at the symbolic level (the fact that my doctor examined me means that they care about me more).

   Remember that your patient will expect you to examine them at least briefly and that you will reassure them by doing this.

3. **Do not use the Electronic Health Record computer in the patient's room.**
   Medical employers and Electronic Health Record companies put enormous pressure on physicians and other healthcare professionals to use the computer in front of the patient. We have conducted blind studies showing that patients perceive a doctor who does not use the computer in the room as more compassionate, more professional, and they prefer that doctor to be their doctor compared to one who uses the Electronic Health Record computer during the encounter. The Electronic Health Record computer has been a source of great frustration for physicians and other healthcare professionals and has led to a considerable amount of burnout, mostly due to the demands for documentation and the rudimentary technology. There is also data that patients don't like it either. Therefore, try to document in the work room and avoid using the computer in front of the patient.

4. **Provide an audio recording of the visit and/or recommendations.**
   Many times, the patient will be able to listen to this information and the recommendations on their way home, and perhaps share it with their loved ones who were not able to make it to the visit. We have also conducted clinical trials that prove that the use of audio recordings has a positive effect on the visit. Almost any telephone provides an audio recording function, and simply encouraging the patient to use their telephone to record your conclusions and main recommendations might be very helpful. Legal departments strongly encourage the use of recording as a way to reduce litigation risk. It is done routinely for some physicians in high-risk specialties.

5. **Have beds and extra chairs in the outpatient rooms.**
   Having a comfortable bed instead of an extra table allows patients to spend more time at the center, especially if you want to conduct a visit that is a little bit longer and you also want that patient to see a counselor, nurse, and other members of the team. Having chairs inside the room allows relatives to enter the room with a patient instead of waiting outside.

6. **Avoid the waiting room.**
   If possible, have the patients go directly into their room when they arrive. In palliative care, patients are frequently in wheelchairs, they're frequently very tired or emotionally distraught, and having them all sit in front of each other in a waiting area can be demoralizing. Allowing them to move rapidly to their room provides them with a level of privacy and comfort that will make the encounter better.

7. **Put some signs and art on the ceiling.**
   Many patients will arrive on stretchers or in wheelchairs to see you. The way art is normally positioned on the walls is not visible to them. By putting signs and art on the ceiling you will make them feel much more welcome to your setting.

8. **Play some music.**
   Retail stores and supermarkets have learned that they sell more when they play music because customers feel more relaxed and are likely to spend more money.

   We have conducted studies that show that patients clearly prefer music in the common areas of the outpatient and inpatient areas.

9. It can be very useful to provide patients information about who you are as a person rather than simply your medical qualifications. In my case, patients that I see in the outpatient area learn that I used to be a DJ, and that I love watching soccer and Bollywood movies. This helps communicate on a more personal level and might help the patient open up to you about them as a person.

   It is important to remember that patients like a doctor less when they deliver a less optimistic message, and the content of your communication will usually be less optimistic. Therefore, you should use all possible gestures of kindness to successfully build rapport, increase the adherence to your recommendation, and improve the well-being of the patient and family.

4. INTERDISCIPLINARY TEAMWORK

"So you have worked on a team: show me your scars!"

Dr. Balfour Mount

From the very beginning of the hospice and palliative care movement it became clear that an interdisciplinary team is necessary to best take care of patients and families.

The multiple dimensions of physical, psychological, social, spiritual, and financial suffering make it very important for the different team members to address these dimensions and each other in a collaborative fashion.

An environment where you are required to work alone or as a dyad with one nurse will not allow you to deliver good care and exposes you to a high risk of burnout.

The number of disciplines needed for successful interdisciplinary care is quite variable.

By definition, interdisciplinary care can hardly ever be delivered successfully at home since it is very hard for all of the different disciplines to be able to visit the patients and the family. Therefore, interdisciplinary care will usually be delivered in

institutions or in the ambulatory care setting. You need to have access to interdisciplinary care for those patients who are at home and have more complex needs.

I have heard Dr. Balfour Mount make this statement a number of times: "So you have worked on a team; show me your scars!"

A successful team requires considerable effort by all of the members to develop an interdependent attitude. The following considerations might be helpful:

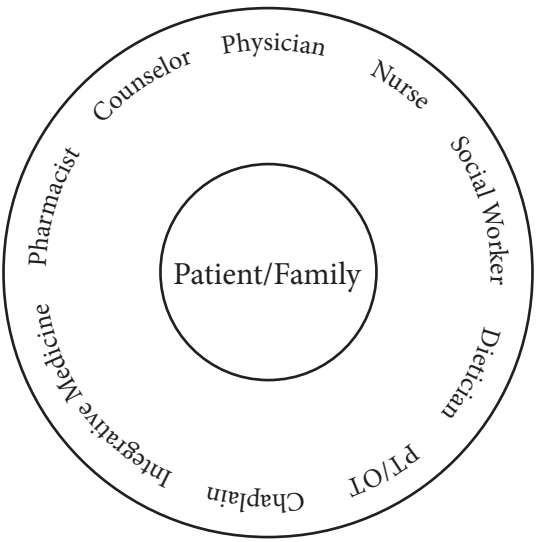
- An interdisciplinary team is not a group of independent disciplines visiting with the patient and the family.
- Multiple disciplines doing an independent assessment and plan of care is harmful to the patient and family, and frequently results in conflict between disciplines.
- Team meetings are important to discuss clinical findings and to generate a common approach to communication with patients and families. This also helps the team communicate with referring colleagues from other disciplines.
- The team meetings should ideally focus on how to address clinical needs and should be kept short and focused to allow team members to move on to care delivery.
- It is extremely important to encourage every single member who had contact with a patient and family to give their opinion. Please remember that 50% of the team members will be introverts and will need a little bit more encouragement to participate.
- Team members who have not had contact with the patient and family should limit or abstain from giving opinions.
- Disruptive team members should be rapidly removed from the team, since their presence and negativity will discourage the other members from participation.
- Interdependence is key to successful team function! The assessment done by a team member should be shared and trusted by other team members. If each of the members who approach the patient and family repeat similar questions this can

be exhausting, and even frustrating, to the patient and family members.

- The vast majority of the disciplines arrive to the team with limited or no experience in complex end of life care; therefore, humility by all disciplines to learn this complex area is of great importance. An individual who comes from a specific discipline and is unwilling to learn how to treat these patients from the rest of the team is probably not going to be an effective contributor.
- Sometimes you might ask yourself why all of this effort is necessary and if it is justified. I remind myself continuously that an outstanding violin player can never deliver the musical experience that we can receive from a number of mediocre musicians playing together in a symphony orchestra. All of us as mediocre professionals can deliver extraordinary care to our patients and families if we practice as a team.

The following figure shows the disciplines most frequently involved in interdisciplinary palliative care. You will not need to have all disciplines involved for all patients, and there will be considerable overlap in the role of the team members.

INTERDISCIPLINARY TEAM



5. COMMUNICATING AND BUILDING RELATIONSHIPS WITH REFERRING COLLEAGUES

It is very likely that you will spend most, if not all (as in my case), of your professional career depending on referrals from other colleagues. When diagnosed with any disease, patients initially want their disease to be cured, or "turned into something like diabetes," so they can continue to function.

Their primary oncologist, cardiologist, respirologist, or family doctor may become aware of the personhood suffering of a patient with a serious disease and ask for your help.

In some healthcare systems automatic referrals are made for certain sentinel events associated with poor prognosis. In these systems you will also need to collaborate with primary disease treatment teams since you will be a consultant; therefore, you will only be able to make recommendations for the care of the patient. Implementations of such recommendations will be dependent on your ability to create a trusting relationship with the primary team.

I have seen multiple palliative care teams collapse in Houston and other cities. A very common reason for collapse is conflict regarding the clinical recommendations. Many palliative care teams criticize the management of physical or psychosocial symptoms, or engage in discussion regarding hospice and end

of life with a patient and family without including the primary referring team. This is particularly problematic when the primary team may still be pursuing active treatment.

If the primary team becomes frustrated they are much less likely to refer future patients to the palliative care team, and then this team will collapse. This is a typical situation of winning a battle for the care of a given patient and losing the war of integrating palliative care into the institution. (I apologize for the military metaphor; having endured the terrible "war on cancer" and "magic bullets" metaphors I should know better.)

Establishing and maintaining an excellent professional relationship with your colleagues is particularly important in the early stages of developing a palliative care culture in your institution (see Chapter 6), and it is the main driver for evolution in your workplace. It will also have great positive impact on your well-being and in preventing burnout.

You need to implement and maintain some useful practices:

- Always thank the referring team for the opportunity to see the patient. On a busy day you may hesitate to thank them, but those of us who have seen how hard it is to come to work not knowing if there will be one single patient referral are always happy to be consulted. It is a great compliment to your science and art that a colleague asks for your help, and you will rapidly improve the well-being of this patient and family after becoming involved.
- Until you build a more trusting relationship with a colleague, make recommendations and ask them by e-mail if they would like you to write any orders. Once you have established a collaboration they will expect that you will proceed with orders in most cases. A small number of physicians never expect consultants to write orders for their patients, so I simply send them a little longer e-mail.

- Keep in contact with the referring team mainly by concise e-mails. Do not abuse their time with lengthy e-mails or phone calls. On the other hand, if you find anything that might be of a serious concern, please contact the referring team immediately in order to avoid blindsiding them when they visit the patient or a relative. If it is a major issue please remember the priorities of harmonious interprofessional communication:

1. In person is by far the best. It allows you to convey messages using verbal and non-verbal skills and it dramatically reduces the chances of misinterpretation. The time you take to walk to their area of work and find them will be greatly appreciated.
2. Telephone allows for verbal communication and the tone of voice helps decrease misinterpretation.
3. E-mail or SMS are immediate, but they are the worst option of the three.

When you use e-mail for communication please consider the following:

- E-mail messages frequently have a *harsher* tone as compared to telephone or in-person communication. Therefore, please be sure to include some nice, positive comments in your message.
- Try to avoid ALL CAPS. They may be perceived by the reader as you yelling at them.
- Avoid "reply to all" whenever not needed. Too many e-mails coming from you increases the risk that a very important message that you sent may not be read.
- Keep it short.
- Be particularly cautious when you communicate with a colleague you don't know. Make sure to include a few introductory sentences about who you are so they better understand your role in this specific communication.

6. THE DEVELOPMENT OF A PALLIATIVE CARE CULTURE

Most hospitals and medical schools have strong structures and processes to address primary and co-morbid diseases. Unfortunately, these same institutions have weak structures and processes for palliative, and overall personhood, care.

The healthcare system is currently disease oriented. Power, academic prestige, allocation of space and resources, and income are all aligned with disease management.

Those who have most of the power in medicine (deans, hospital presidents, department chairs, pharmaceutical industry executives, and ministers of health) become powerful by successfully navigating in a system that traditionally has not valued the care of the whole person.

A few of them will charge against the windmills like Don Quixote; they will get beaten up multiple times, and they will end up poor and lonely. The majority will then learn to behave like Sancho Panza and that going with the flow is healthy for them. Consequently, palliative medicine has developed at a much slower pace than many younger, organized specialties of medicine, such as oncology, critical care, or emergency medicine.

Adoption of our field is happening, but we are far from being considered a major specialty.

It is likely you will face various levels of adoption of our field. Years ago I published a method, in the *Journal of Palliative Care,* to diagnose the stage of development of a palliative care culture and possible ways to manage each of those stages.

These stages are applicable to individuals such as your boss, and to institutions or health regions. They each need a different approach and there is always a possibility of regression when a new boss arrives, or if there is a funding or political crisis.

THE 4 STAGES OF CULTURE DEVELOPMENT:

1. ***Denial***
2. ***Palliphobia***
3. ***Pallillalia***
4. ***Palliactive***

The stages in the development of a palliative care culture include:

1. **Denial:**
   At this stage individuals and organizations believe there is no need for palliative care in their environment. These individuals and programs make statements such as "Our patients are well taken care of by a hospice referral." From an academic perspective, leaders frequently make statements such as "There is not enough need for this subject to be included in the undergraduate or postgraduate medical education curriculum," or "These problems of physical and psychosocial suffering are not worth funding and/or publishing in our journal or presenting in our congress."

Please be careful with individuals that make these statements. The way we talk reflects the way we think, and that reflects the way we act. Individuals in this stage of adoption of a palliative care culture are unlikely to provide funding for clinical and/or academic programs since they truly believe this is a waste of resources and time.

While denial has decreased in the United States in the last 10 years, it still remains prevalent in many academic institutions and among leaders from older generations; it is also highly prevalent in the developing world.

One of the most important ways to address denial is to meet patients in your institution and measure, in very simple ways, their level of physical, emotional, spiritual, and financial distress.

Please remember that the leaders of the prevailing view are much more powerful than you are, that "in the absence of data all opinions are good," and that their opinion will be more powerful than yours. Therefore, collecting data and presenting it will go a long way in helping that institution or that individual move on from the stage of denial to the next stage.

2. **Palliphobia:**
   At this stage the individual or organization develops fear that results in anger against the palliative care team. Common statements at this stage include "This is covered euthanasia," "This will be bad for the reputation of our institution," "This will lose money," and "This will cause problems for us when we put patients on research studies or when we treat them for their primary disease."

   At this stage it is possible that your administrative leadership will invite you to give a major lecture in the auditorium. This may not be a very good approach since you still do not have any data to support how you can help referring doctors and the institution. A better approach is to establish an alliance with a small number

of referring physicians and advanced practitioners, and start seeing their patients. Once a considerable amount of patients have been seen it is now possible to document the decrease in their suffering burden, along with the improved well-being among those referring clinicians. With this data in hand it is now possible to start making presentations. In all those presentations it is important to not worry about individuals who are overly hostile to the program. The success of your program and you as a professional does not depend on those individuals. Your success depends on maintaining the support of the physicians that are now referring to you, and the physicians who have not referred to you yet but do not have clear hostile views about you and your field of work. These individuals are likely to refer patients to you based on the experience of those pioneers who made the initial referral to your program; therefore, discussing with them and using them as references is very helpful.

The same can be said about your academic development. By starting to conduct simple research in collaboration with other individuals you will demonstrate that there is a body of knowledge to be created and this will encourage others to approach you.

3. **Pallillalia:**
   This stage is the most dangerous in the development of a program. It basically consists of repetitive nonsense statements in support of palliative care while not doing anything tangible to advance its development.

   Common statements at this stage include "This is very important" and "This is a major priority," but there is no significant allocation of resources and space to allow you to do the work. This results in rapid burnout of clinicians and researchers within this program, and most of the clinical and academic programs I have seen collapse over the years have been at the stage of pallillalia.

A simple statement that the team is working too hard and has limited resources will not be convincing to an administrative leader, even if they are sympathetic, since many programs make similar claims all the time.

Benchmarks traditionally used in medicine are not very helpful because the encounters in palliative care are long and the burden of the suffering can be quite significant. It is also harder to publish in this field due to lack of support from granting agencies and even philanthropic organizations.

It is important for you and your team to compare your professional burden with that of other specialists working in your institution.

In one case, we found that parking records measuring the arrival and departure of clinical faculty was helpful in making the case for a longer day for our clinical team.

Sometimes asking for an external review by well-recognized academic leaders can be helpful in convincing the individual in charge that increased support is necessary.

Sadly, it is frequent that only through the resignation of the program leader will institutions finally accept that a program is under-resourced and under-recognized.

4. **Palliactive:**
   In this final stage of development the leader and the institution will not only recognize the importance of the program, but will also provide the necessary resources and administrative arrangements to support the program.

   We have discussed before that administrative arrangements are extremely important for the safety of the clinical and academic team. An administrative structure, such as a department, provides fair benchmarks for comparison of productivity. Individuals that are scattered among different departments and divisions

are frequently measured using benchmarks that don't belong to their reporting areas, are frequently at high risk of receiving unfavorable evaluations, and face completely unreasonable expectations of clinical and/or academic productivity.

A palliactive institution will also provide the necessary space and resources for the palliative care faculty to operate at a level that is similar to that of all other individuals practicing in that setting.

It is important to recognize that regression to a previous stage can happen at any time, especially when there is change in leadership or significant turnover in clinical staff.

When you enter an institution or group practice for the first time it will be important for you to become familiar with the culture of the place where you work and also to understand the developmental stage of palliative care culture within that place. This will allow you to develop a strategy for cultural development.

It is always safer and more rewarding to practice in a palliactive culture and environment.

Unfortunately, almost no academic medical center in the United States has reached a full palliactive stage. Many of us share the three most important palliactive goals:

- Every hospital with an ICU will also have a PCU.
- Every outpatient care facility will have an independent outpatient Supportive and Palliative Care center.
- Every medical school will have an independent Department of Palliative Medicine.

PSEUDO PALLIACTIVE

Some for-profit hospices make money by delivering minimal care. This includes avoiding even less simple diagnostic interventions and drugs. Some for-profit palliative home care or hospital care

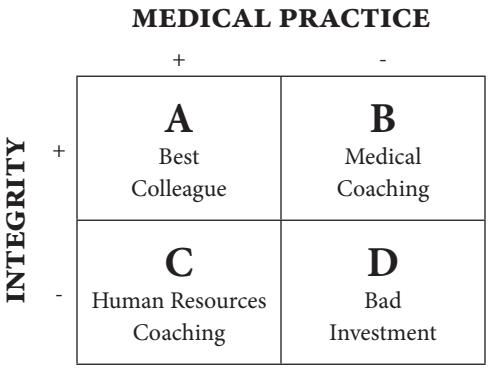
companies also aim at reducing financial burden for the insurance company, even if the patient and family receive less care. Be careful with these employers since they can be more harmful to your career development and your health than those in pallillalia or palliphobia.

7. DIAGNOSING A COLLEAGUE (AND OURSELVES)

MEDICAL AND INTEGRITY ISSUES

It is not uncommon that problems will emerge between colleagues regarding professional practice. It is also quite frequent that individuals that are clinically or academically very productive are allowed to engage in practices that show lack of integrity. On the other hand, it is also possible that people who are perceived as being quite nice to the group are allowed to practice in a medically incompetent way. Our Administrative Director, Natalie Schuren, taught me this important issue.

A useful way to understand the performance of a colleague, or ourselves, is to put together a 2x2 table like the one shown on the next page. The plus sign means that the performance is appropriate in a certain domain and the minus sign means that the performance is inappropriate in that domain.



The best scenario is to have a plus in both our medical practice and integrity (Box A).

Some individuals with a positive medical practice engage in unprofessional behavior, such as not doing their share of the work, being impolite, generating a hostile working environment, and displaying an overall narcissistic and antisocial behavior (Box C). These individuals need coaching on their behavior as a colleague, and it might be important for them to understand that being a negative team member is a potential reason for termination. If this describes a potential mentor or boss you should consider avoiding these individuals. In my experience, Box C individuals are the most harmful to institutions and colleagues, even though many of them achieve great academic and financial success for themselves.

Some individuals conduct substandard medical practice, such as incomplete or wrong assessments, excessive or insufficient use of diagnostic investigations, poor pharmacological practices, or poor counseling and communication with patients and families. These individuals need medical coaching even though they display high integrity as team players (Box B). A common error is to avoid having the difficult conversation about coaching needs, because they are "a nice person," until their errors become so severe that patients get hurt and termination is required.

Lastly, sometimes there are individuals that perform very poorly in both areas and it may be very difficult to work with them; therefore, it might be a good decision to completely avoid associating with them (Box D).

8. ACADEMIC VS NON-ACADEMIC CAREER

I am a bit biased since I always chose to work in an academic environment. I received many offers to move into non-academic practice over the years and considered some seriously. Some of my closest friends work in non-academic settings. There are some issues to consider regarding which might be the best setting for you.

SOME ADVANTAGES OF AN ACADEMIC PRACTICE

Most physicians like to read and learn new information and skills. In academic environments there are always lectures, seminars, and courses, as well as electronic and physical libraries that facilitate the process of lifelong learning.

Teaching is one of the most effective ways of learning. The teaching environment stimulates physicians to keep up to date with medical literature and to learn ways to transmit and apply such knowledge in the clinical setting. We will be discussing this in more detail later on.

An academic environment provides the support required to start and maintain a research-oriented career. Research allows you to study specific aspects of your practice in more depth. It

can also protect you from burnout by bringing more variation to your professional practice and the hope that your contribution will improve the overall state of knowledge and practice in palliative care.

SOME DISADVANTAGES OF AN ACADEMIC PRACTICE

Academic positions will result in a much less independent practice in all aspects, especially with regards to clinical and administrative arrangements. Clinical practice, including patient evaluations, pharmacological interventions, and non-pharmacological interventions need to be negotiated and coordinated with other clinical members of the team.

Due to the group practice arrangements in most academic centers, there are expectations of clinical productivity and the need to coordinate absences, including vacations, participation in congresses, and other activities, with other clinical members of the team.

Some physicians do not like teaching and are not willing to learn how to do it well. This requirement is universal for those involved in an academic practice.

Finally, research can also be demanding, frustrating, and a source of conflict with colleagues, staff, and supervisors.

An academic life will require careful identification of a mentor, and promotion to the rank of Associate Professor will require the junior physician to fulfill a series of specific requirements of productivity.

The decision to pursue an academic career rather than a non-academic career is rarely ever a one-way bridge, and that means that after a few years it is always possible to shift to an alternative practice. It is important, however, to recognize that it is a little bit easier to move from an academic to a non-academic practice as compared to vice versa, given the requirements for research and teaching productivity associated with starting an academic life.

9. MENTORSHIP

The mentor can be very useful, but they also have the potential to be the most harmful to your career development. It is therefore very important to carefully select your mentor. Many academic institutions appoint a mentor for their junior faculty. This is sometimes a bad arrangement with potential for conflict of interest, a lack of confidentiality, and trust problems. In these cases it would be useful for you to secure another unofficial mentor in addition to the one appointed by your direct supervisor.

HOW DO YOU CHOOSE A GOOD MENTOR?

Many junior faculty look for someone who has achieved success in the area in which they want to succeed: major research publications, grants, administrative appointments, awards, invitations to lectures, etc. These achievements only mean that this person was able to help her/himself. Being a wonderful speaker and a friendly and energetic leader does not necessarily make a good mentor. The mentor you need is someone with a track record of helping other junior faculty achieve promotion, publications, grants, and administrative leadership.

Feel free to ask questions to the potential mentor and/or those who work with them. If they are unable to identify a significant

number of successful mentees after many years in academic life you should run away fast.

They may not really know how to mentor, or they may use your energy and talent to achieve their goals rather than yours.

KNOW THYSELF

Before finding the right mentor it is important for you to decide in which aspect of your medical and/or academic career you would like to excel. This will help you and the mentor decide if this will be a good collaboration. After a few meetings a potential mentee told me that she had found that her career goal was to become the director of a cancer center. This discovery made it easier for both of us to decide that I was not the right mentor for that type of career goal. (For more on career goals see Chapter 10.)

The four main domains of practice where mentorship might be applied include clinical care, research, teaching, and administration. All four components are important for promotion and job satisfaction, but not all require mentorship. The nature of your job and what matters to you and your employer will help you and your mentor identify which domains should be emphasized in your regular meetings.

LONG-TERM COMMITMENT

It is important to identify specific goals for the mentorship; promotion to Associate Professor, an R01 grant, achieving tenure, and becoming an administrative/research director are frequent goals for mentorship.

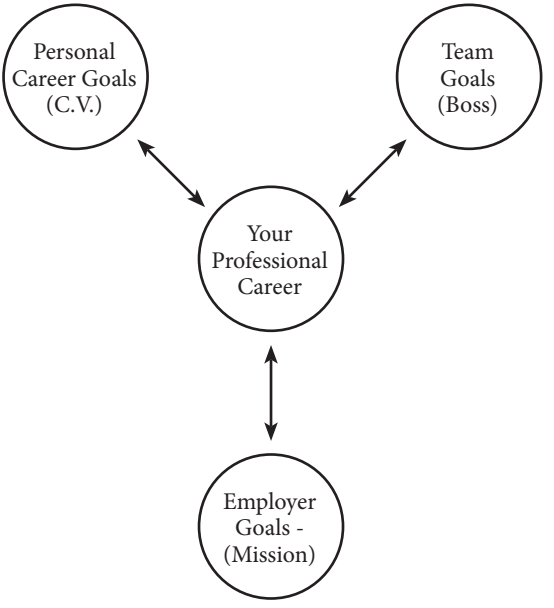
All of these require a minimum of one-hour monthly meetings for reviewing goals and setting new goals. One of the most common mentoring goals is to achieve promotion to the rank of Associate Professor in approximately six years. By the time this is achieved

my average mentee has met with me one-on-one for approximately 120 hours. It is useful to follow a semi-structured format in which the mentee reviews the level of achievement of all the goals for promotion for the first twenty minutes, followed by discussion of specific projects for the remainder of the hour. This gives the opportunity for both participants to review the career progress every month, to make any necessary changes in short- and long-term goals, and even to set a date for achieving the final goal (promotion, R01 grant, etc.).

After the main goal has been achieved it is sometimes useful to maintain less-frequent and less-intense meetings on an as-needed basis. Over the years, I have learned that coaching junior faculty to achieving their goals has been one of the most rewarding aspects of my career.

10. YOUR CAREER GOALS AND HOW TO ASSESS EMPLOYER TOXICITY

Throughout your career there will always be a balance and a certain tension between three types of goals, as shown in the following figure.



CAREER GOALS

We previously mentioned the importance of being aware of your own career goals (Know Thyself) and how they align (or not)

with the goals of your team (clinical teams; department) and the institution where you work.

I have learned over the years that wrong career goals are among the most frequent causes for career dissatisfaction and burnout.

You may start your professional career following the traditional statement of "you can be anything." In palliative care, and overall in a medical career, this is not true and I do not know how to coach you for that. Trying to be *No. 1, The best, The boss, The hospital president,* etc. are bad metrics. The main reason for this is that those outcomes are very likely to be influenced by factors that you cannot control. For example, there might be issues such as an opening for the position you want when you are not prepared to take it or in a location where you cannot move, and having a friendly or unfriendly reviewer for a grant or an employment position. In some cases you will lose to a colleague who is prepared to behave with less integrity, such as taking first authorship of a paper or grant when they didn't work as hard as you or others, running with your idea and writing a paper or an industry grant with it, or simply lying about their achievements or yours.

The obsession with being *No. 1* is always concerning since there will always be someone who has more publications, more power, and more income than you, and this might result in a considerable amount of frustration.

There are wonderful career goals that you can control and I feel reassured when I hear those goals. These goals include: 1) to help suffering patients and families using the best knowledge available; 2) to conduct independent research and publish the research findings as a way to contribute to and improve the field; 3) to teach the new generation of physicians and other healthcare professionals; 4) to organize clinical and academic programs to improve the state of the art in our field.

As a consequence of doing this work you may or may not become a hospital president or dean. Paradoxically, many times achieving those positions of great power end up being a distraction from achieving our true long-term career goals.

One useful way to define your career goals is to reflect on your legacy. Most of us want to feel that some of our work will survive after we are gone (that is one of the reasons why wealthy people like to put their name on buildings or endowed chair positions). What would you like to leave behind? It might be your research paper and discoveries, the students and fellows you educated, the clinical programs you established, your contributions to national or global organizations, and/or the grateful memory of the families you helped through very difficult times. Since we are all different, your legacy goals are likely different from mine and might guide your career goals.

It is important to harmonize your personal growth needs (Know Thyself) with the team goals, including the overall clinical and academic responsibilities for the division or department where you work and the distribution of burden of care and academic activities. This harmonization should allow you to populate your CV with presentations, publications, lectures, completion of courses, participation in committees, administrative responsibilities, etc. These personal growth and team goals need to be balanced with the goals established by your employer.

Some employers will predominantly emphasize clinical productivity and financial outcomes while others will emphasize primarily academic achievements. It is quite likely that if you have a clinical and academic appointment as part of your job the hospital will primarily emphasize your clinical productivity while the university will primarily emphasize your publication and teaching record.

HOSPITAL	UNIVERSITY
Clinical	Clinical
Administrative	Administrative
Teaching	Teaching
Research & Publications	Research & Publications

This tension in priorities can frequently help you negotiate a balance in the four main domains of your medical career.

It is important to recognize that the team structure and goals, as well as your employer's structures and goals, might change over time, and therefore, you need to recalibrate the arrows that connect all these three areas of work. My first boss and mentor in Canada, Neil MacDonald, used to tell me that "administrative arrangements are important." I did not completely understand the great importance of this advice until many years and some errors later.

> ***"Administrative arrangements are important."***
>
> **R. Neil MacDonald**

Academic medicine has traditionally had very few layers of power: Assistant Professor, Associate Professor, and full Professor. This leads to collective governance by administrative committees with full participation and decision making by colleagues from all ranks. Seniority gives faculty access to more income and reduced clinical productivity demands, but the concept of a colleague as a peer and an equal has dominated the structures and processes of clinical and academic medicine. Burnout is much lower in places where the high responsibility of clinical care is accompanied by autonomy in decision making.

Unfortunately, many academic and non-academic hospitals and healthcare organizations are operated by companies, and physicians running these organizations follow management principles learned

from MBA or leadership courses. They frequently establish multiple "vice president" positions and set incomes and bonuses based on criteria set by the company. In this new role the physician vice president has a significant conflict of interest: they continue to be part of the medical staff and even participate in medical and scientific organizations, but they essentially advocate and respond to the interests of the company.

You may recognize these institutions by their considerable number of vice presidential roles, their frequent overruling or elimination of committees as decision-making bodies, and their more vertical structure that concentrates power, salary, protected time, and infrastructure support in a small number of individuals. This small number of individuals has great autonomy, but the responsibility for the outcomes of clinical care and high-quality research are still attached to the rest of the faculty. In my experience these are not healthy environments, since high responsibility with low autonomy is the perfect recipe for burnout. I suspect that the proliferation of entrepreneur/manager/vice president positions is the culprit behind a significant proportion of the burnout epidemic among physicians. The type and duration of medical encounters and the type of allowed medical interventions, including the type of drugs, the availability of inpatient beds, outpatient templates and on-call schedules, are decided by the vice presidents instead of by committees of peers. You will need to do some research to identify some of these toxic employers:

- Try to find out if there are many layers of vice president positions.
- Find out if there is a high turnover rate of MDs and RNs.
- Meet with colleagues at your rank level in private and ask directly about the level of autonomy they have to participate in collective governance of the institution.
- Ask colleagues at your rank level in private if they see themselves working in this place in ten years or if they see this as a short stage in their career development.

- Ask if the leadership promotes collaboration or competition within the team.
- Ask how the institution and departmental leadership supported someone who became seriously ill or experienced the death of a loved one.
- Ask if the leader frequently quotes business companies instead of great hospitals and universities as examples to emulate.
- Meet junior colleagues and ask how much information they have about salaries, workload distribution and overall financial status of the division/departments. Secrecy is frequently a bad sign.

Potential employers who say "trust me" are concerning. Send them a nice e-mail summarizing your understanding of working conditions. This will be of great value if there is any attempt to not deliver on promises.

I would stay away from institutions and leaders that abandon the principles of medical governance in support of a purely business-based model.

An institution that hurts colleagues will not make an exception for you.

It is important to understand that institutions change (and not always for the worse; many times for the better, especially in their support of person-centered care and palliative care in recent years). If the institution where you work starts to show signs of becoming a toxic place it is very important for you to recognize it early and quickly move away.

> ***"Institutions do not love you back."***[2]
>
> **Joseph Simone**

2 Maxim JV. *Simone's Maxims: Understanding Today's Academic Medical Centers*. North Fort Myers, FL: Editorial Rx Press; 2012.

Dr. Joseph Simone, in his wonderful book *Simone's Maxims,* states that "institutions do not love you back."[3] I am frequently concerned when I hear someone say "I love this hospital. I cannot imagine working anywhere else." Organizations, leaders, and staff change all the time and working conditions can become much better or worse rapidly.

It is unlikely that you will be able to change your boss or the institution. You can then do two things: 1) Reinvent yourself and learn how to abandon things you liked to do and learn to like the things you will be asked to do; 2) Change jobs.

There is great danger in not doing either of the two. If you decide to stay and fail to reinvent yourself according to your new job demands, the leadership may consider you negative or incompetent and fire you. Time is also of great importance: ten years delay to open the palliative care unit or the outpatient supportive care center they promised you, or in getting you that day and a half of academic protective time, is nothing in the life of an institution, but they are the ten most productive years in your career. You will become much less attractive to any possible employer after ten years of not having much personal growth to show in your CV.

Ultimately, the decision about where to work and when to move can only be yours. No one else can decide for you. The reason for this is that all professional decisions are ultimately personal decisions. I can only advise a junior faculty, fellow, or mentee about job-related issues. It is important to understand that your job is only one important aspect of your personal quality of life; a decision that is not good for your career may be, on the other hand, wonderful for your quality of life and it can always be reviewed every few years.

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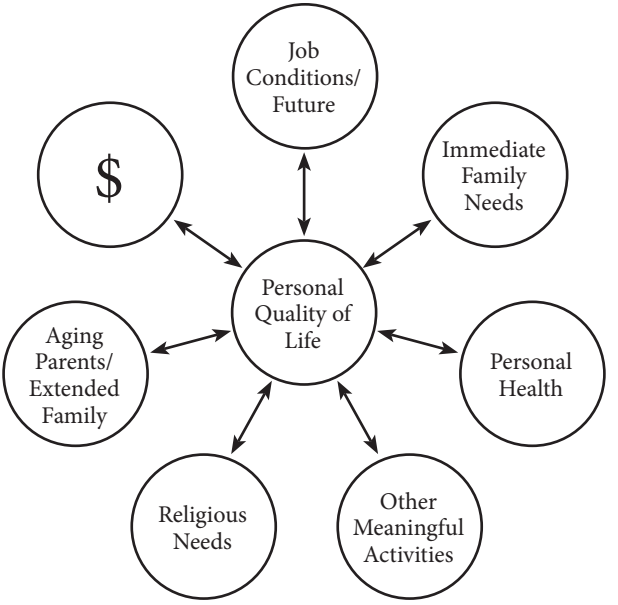
3 Maxim JV. *Simone's Maxims: Understanding Today's Academic Medical Centers.* North Fort Myers, FL: Editorial Rx Press; 2012.



This chapter and all others in this book are aimed at you as a junior physician. The discussion of the benefits of a more toxic environment in achieving financial or even clinical outcomes is beyond my knowledge and the purpose of this book. However, I am quite sure that a flat, collegial, fair, and supportive administrative structure that emphasizes dignity, respect, and stability is the best for you, even if in the medium or long term that hospital, healthcare organization, or university goes bankrupt. You will have grown personally and professionally, and you will be healthy and able to move on to the next place in a position of leadership. In the process you will have learned to lead a flat, collegial, and supportive team that will emphasize dignity, stability, and respect.

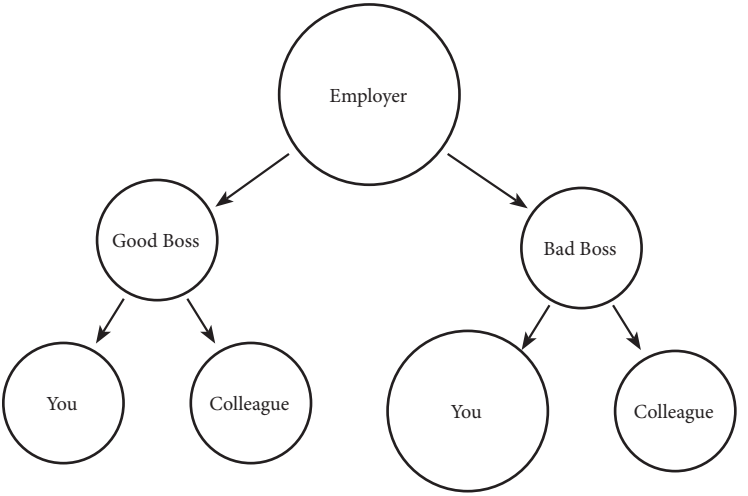
BOSS OR LEADER: THE DIAGNOSIS

The institutional culture matters. However, I have learned that within a certain cultural environment, there is a wide variety in the morale and burnout of physicians. Your boss can have a major positive effect to ameliorate a negative culture, or a major negative effect that destroys the benefits of a positive hospital or university culture.

There are some useful signs that will help you recognize when your boss is also a leader:

LEADER	BOSS
• Will share the difficult parts of the routine (on-call schedule, difficult patients, situations of conflict)	• Will avoid the most burdensome or conflicting aspects of work
• Will share in the success of paper authorship, invitations to conferences, successful clinical care of difficult patients	• Will take first authorship, and promote their own name for appointments and awards
• Will assume responsibility for the errors of the team	• Will blame team members for many of the errors
• Will be attentive to the needs of the team	• Will be predominantly attentive to their own needs

The following figure might help you understand burden distribution in different financial circumstances:



As previously mentioned, in the complex balance between your professional goals, the team led by your boss, and the overall institutional culture, you are unable to change the boss and the institution. Therefore, once you recognize that either the institution or the boss is toxic it is very important to move out of that environment. In some institutions it is recognized that your direct boss might be responsible for at least 50% of your level of burnout, and that is why rapid recognition and moving on might help protect your professional well-being.

11. ORGANIZING, MANAGING, AND PARTICIPATING IN MEETINGS

You will spend a significant proportion of your professional life in meetings.

The majority of the meetings I attend are at best unnecessary. Some are unfortunately too long, demoralizing, and misinforming. Many physicians adhere to the philosophy of "80% of success in life is showing up." Shri Henkel, in her wonderful book *Successful Meetings,* reminds us that when you are responsible for the meeting "you have the power and ability to make the meeting a flop or a success."[4] Shri Henkel's books are predominantly aimed at the business world, but most of the concepts are quite applicable to clinical and academic medicine.

> ***"You have the power and ability to make the meeting a flop or a success."***[4]
>
> **Shri Henkel**

When your role is to make a presentation in a meeting you can follow the recommendations in Chapter 13 (How to Give a Lecture). As in the case of lectures, making presentations

4 Henkel SL. *Successful Meetings: How to Plan, Prepare, and Execute Top-Notch Business Meetings.* Ocala, Florida: Atlantic Publishing Group, Inc.; 2007.

at business meetings requires a good understanding of why you are invited to present and who are the participants. Unless the participants are all very familiar to your body of work and your program, it is always important to start with some background. This will put your presentation in perspective and will also help you educate while saving face for those who should know what you do, but may not remember.

Make sure that you avoid, as much as possible, acronyms that become very difficult for participants to follow in future slides or during the course of the discussion.

ORGANIZING AND MANAGING A MEETING

- If your goal is to provide information, a face-to-face and/or video meeting may not be necessary and you should consider simply sending an e-mail. On the other hand, sometimes you need to provide information and to request feedback from participants. If this is the case, it is useful to send the information as an e-mail before the meeting and to clearly explain that the purpose of the meeting is to rapidly review this information and to ask for their participation in planning next steps.
- Regularly planned meetings are always a challenge. It is important that dialogue and participation takes place. Approximately half of the participants in the meeting are extroverts and they will always let their point of view be known. The other 50% are introverts and they have exactly the same talent and insight into the problem as the extroverts, but they need to be clearly prompted to participate. If only the extroverts participate you will miss 50% of the talent in the room. It is therefore useful to go around the table asking for everybody to voice their views and their opinions.
- It is impossible to obtain universal agreement on all subjects all the time. Consensus is usually defined as 70% to 80% agreement. If any decision or action is postponed until complete agreement exists this will in fact be a decision in favor of the 20% who are clearly expressing disagreement. This *analysis paralysis* becomes

quite frustrating and might put the future attendants in jeopardy of participating.

- Make sure that all the participants that are necessary for a decision are present. If they are not able to make it, ensure that they are present by telephone or video. There is good evidence that video is better than telephone, especially in generating participation. However, this only works if the video system and the screens are good enough to allow for very good visual contact among participants. Do not conduct a meeting without the necessary participants since the lack of decision making will frustrate the ones who attend and will jeopardize future interest.
- As in the case for lectures, always end your meeting a few minutes early. Participants will be delighted to see that you respect their time and will be more likely to adhere to future meetings.
- Some individuals will not be able to attend some meetings due to competing personal, family, or health issues. It is of great importance to respect those needs as long as those individuals are behaving with great integrity in other aspects of their professional life. It might be necessary to change the time or to ask them to make a particular effort in those occasions when their participation is particularly important.
- Other individuals are consistently absent from scheduled meetings, are constantly checking their telephone and looking withdrawn when they are present, or consistently arrive quite late. With regards to these individuals, it is important to meet them one-on-one and understand what motivates their behavior. A consistently negative participant creates a very uncomfortable environment for the others, and a participant who gets away with not showing up or showing up too late raises concerns about fairness when all the other participants are making big efforts to attend and be on time.

12. RESEARCH AND PUBLICATIONS

Publications will be an expectation if you have an academic appointment. They will also help a lot in your professional growth if you do not have an academic appointment.

When your academic appointment has increasingly more protected time, the requirement to publish and to obtain grants to support your research increases. Even when your position is primarily aimed at education and your protected time is limited, your institution and your colleagues will greatly value that you present to scientific congresses and that you publish in peer-reviewed journals.

There are limitations to research and publications in palliative care.

Our specialty was born on the fringe of healthcare during the 1960s in a suburb of London. All the basis for our current practice, including the assessment and management of symptoms, psychosocial care, spiritual care, family care, end of life care planning, and bereavement support, were established more than 50 years ago. However, it took much longer to establish palliative care than much younger specialties, such as critical care medicine, emergency medicine, and medical oncology. The main difference is that those specialties were born 10 years later, but within organized medicine. There are also many sophisticated clinical settings where research

in mainstream areas can be conducted, such as intensive care units, emergency centers, and stem cell transplantation units. Unfortunately, there are still very few palliative care units and outpatient supportive care centers, even in cancer centers.

These limitations provide great opportunities to publish, since the body of knowledge in our field is much more limited compared to other specialties; many times, a simple description of findings can be published and presented in meetings.

Your patients have a number of severe physical, psychosocial, spiritual, and financial problems. Their family has major problems associated with the physical and emotional care of the patient, work, money, transportation, access to doctors and drugs, as well as the structure and function of the family itself.

In palliative care, our clinical programs are the laboratory and the classroom. Both education and research are much easier and effective when the clinical programs are good. It will be difficult for you to conduct a very successful publication career in an environment where the care is substandard.

It is also critical to understand that the urgent (daily clinical care) can destroy the important (clinical research). It is very important that you generate space so that research can be conducted by yourself or other team members in a way that is not continuously interrupted by clinical events.

WHAT TYPE OF RESEARCH?

It is not a good idea to start with randomized controlled trials or complex, long-term cohort studies. From an investment perspective those are true junk bonds that are fraught with all kinds of potential reasons for failure; most importantly, the reasons are typically out of your control, such as decisions from funding agencies, decisions from the institutional review board, patient accrual, loss of data, etc. You read in Chapter 10 (Career Goals) that those areas that you

cannot control are the ones most likely to cause burnout and lead you to abandon a potential research career.

Dr. Waun Ki Hong, one of the great academic oncologists at MD Anderson, used to say, "You have to catch small fish before you can catch big fish," referring to publications and grants.

Case reports, research letters to the editors, retrospective studies, cross-sectional surveys and cross-sectional studies, perspective pilot studies, and randomized controlled trials are all valuable methodologies, and over time I have learned a lot from each and every one of these types of publications.

KNOW THYSELF

As in the case of your career goals, with regards to your research it is extremely important that you understand the clinical setting where you work. It is not in your best interest to engage in research that studies a problem that you rarely see or that you plan for long-term follow-up of patients that on average you only see once or twice. It is important to know the most frequent diagnoses that you see, the frequency of visits of these patients, the average survival, the types of complications they experience, and the most common treatment they receive. It is also very useful to understand the level of education and age of your patient population.

THE IDEA

How do you get an idea for a study? Sometimes clinical observation can lead to a study. In our case the observation of decreased sedation with methylphenidate, and the successful use of the subcutaneous route where an IV was not available, inspired our prospective studies. In other cases, the literature can help when you read case reports or letters to the editor. We found it very useful to read letters about the effects of corticosteroids for nausea and fatigue, and the use of donepezil for sedation. At this point it is important

to remember that there is an enormous amount of ignorance in our healthcare professions about what happens close to the end of our life. We do not know if water helps and who is helped by hydration at the end of life. We do not understand if oxygen is helpful for dyspnea. We have been using the same analgesic group for 80 to 200 years. We do not know if there is anything better than haloperidol for delirium (the way most of us and our families will die). We do not really know which type of conversations work and how and what we should say in those conversations. We are fortunate that our field has open-ended questions in almost every aspect of our clinical practice.

You should look for ideas within a field you are passionately interested in. This is because you will have to spend long hours reading and thinking about this subject.

It is important to conduct a literature review immediately after you have an idea. This requires a little bit of time because palliative care literature is frequently scattered within palliative care journals, oncology journals, and other publications. It is very important that you do not read too much. It is not that important if your idea has been published in one other case report 30 years ago. You just want to make sure that there are not three or four recent large papers on exactly the same subject you have in mind. This has happened to me and conducting a literature search about my idea saved me a lot of time and frustration.

One of the main reasons to do a literature search is so that you can use a lot of the methodologies that have been published by other authors. Once peer reviewers have accepted a certain approach to measurement or interventions it is much more likely that this will be accepted as part of your proposal.

THE RESEARCH TEAM

Research is always a team sport. It is important to have different teams for different projects. A usual team has the following:

- A content expert. While this might well be you, it would also be nice to have someone else with expertise in the subject you will be studying.
- An expert in methodology. If you are going to do a survey, qualitative study, or clinical trial, it is nice to have someone who may know nothing about your subject, but who has done successful studies using such methodologies.
- A clinical research nurse/assistant. It is important that they be involved from the beginning to provide some logistic advice about the feasibility of what you are planning to do.
- A biostatistician. It is critical that you involve them from the beginning, even for retrospective studies or cross-sectional surveys.
- It is important that you take on all the major tasks. These individuals are not there to write your protocol, your grant, or your report. They are only expected to provide you with advice on the best way to do things.

The mentor has already been addressed in Chapter 9. It is very useful to have a reasonably in-depth conversation with your mentor before moving on to getting your research team together.

It is important to avoid meeting excessively so that you don't exhaust your team. Also, to keep the team productive and happy it may be necessary to ask unproductive members to leave the team early on. One of the most difficult aspects, but a crucial one, is to close studies that are not feasible early on so you avoid wasting time and effort from all members of the team.

Authorship should also be discussed at the first meeting. The vast majority of publications now allow two first authors, and those should be addressed as a way of preventing conflicts later on. It is

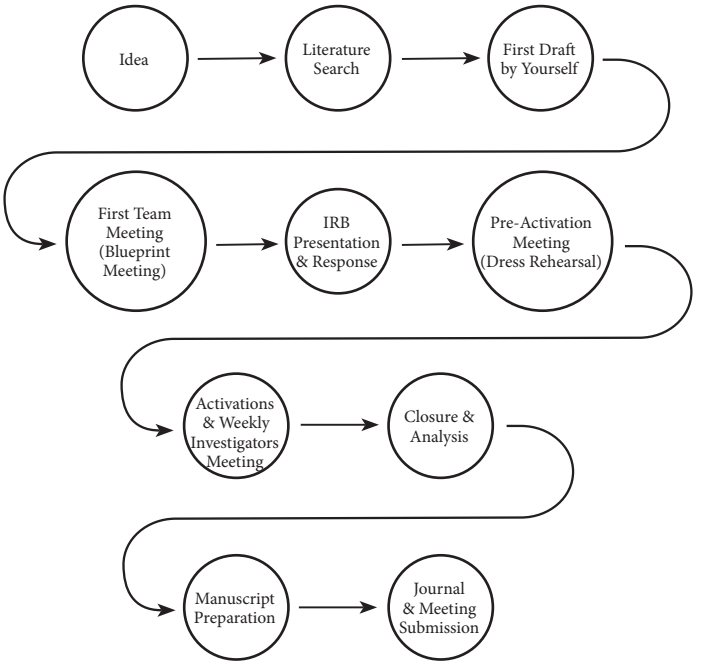
important to share first authorship with team members. Most of the time the database will allow for a number of secondary studies and this gives the opportunity for other team members to present in congresses and become the lead author.

It is also very important to discuss if there is any funding, in a very transparent way, as a way of preventing conflicts later on.

Dates for stage completions and deliveries must be outlined, and this is especially important with regards to the biostatistical part of the paper and/or grant application since that requires very strong input from your biostatistician, and you will not be able to write that yourself.

RUNNING THE STUDIES

The following figure summarizes the steps you need to follow from idea to publication.



In previous paragraphs we have already discussed the idea and literature search. Before the first meeting with the team it is important that you prepare a draft of what you would like to achieve in your study. Your mentor can help you prepare this. It is also very important to have a first draft before the first meeting to save time and effort for all participants.

For many years we have called our first team meeting the blueprint meeting. We have already discussed the importance of the members of the research team and ideally all of them should be asked to participate in person or by telephone. This meeting will complete the discussion about the ideal study, and you will be responsible for making all the necessary changes in the protocol and sending it back to individuals that are particularly important, such as the biostatistician. Once the final protocol is ready it can be submitted to the Institutional Review Board (IRB). Everything you intend to publish must be presented to the IRB, including case reports and retrospective studies. It is therefore important that you follow this blueprint process for every single study you will conduct, rather than only for prospective clinical studies.

After the IRB has approved your study you should conduct the other extremely important meeting; we call this pre-activation meeting the dress rehearsal. If we are activating a research study it is important that you or another team member play the role of a patient and ask those who will be proposing participation in the study to explain what the study will involve, obtain consent, and conduct all the evaluations on you as if you were a patient. If the study is a retrospective study all the team members should go together into the Electronic Health Record and identify where the information will be found and how to put this information in the database. The dress rehearsal allows everybody who will be involved in the data collection to feel comfortable with their roles in the study. It should be conducted no more than 3 to 4 days before the research team will start collecting data so that all aspects of the study are fresh in their memory.

During the course of this study a weekly meeting will be very important to identify technical problems that might emerge, and to see the patient and/or chart recruitment process. These meetings must be attended by you and those that are involved in the day-to-day running of the study. There is no need to ask other scientific experts or the biostatistics team to attend these meetings. Once the data has been collected, it is time to close the study and clean the files before submitting them to the biostatistics team for analysis. There will be need for considerable back-and-forth interaction between the investigators and the biostatistics team. It might be very helpful to start preparing the tables and figures, since this will help guide the analysis performed by the biostatistics team.

This process is followed by preparation of the manuscript. Ideally, the manuscript should be ready and submitted to a journal at about the same time the abstract is submitted for presentation at a meeting. This will save everybody, including yourself and the biostatistics team, from the need to look at the data twice, once for the meeting and another time for final publication.

Each of the stages of program development described in the figure will take days to months to complete, and there will not be much for you to do while you wait for meetings and reviewers' comments. It is therefore very useful to have multiple projects going on simultaneously, so that if you find a few hours, you will always have something to do. Each of the steps should be broken into multiple activities of short durations (e.g. Find 3 references on chronic nausea in cancer, send a new table 3 to the biostats team, etc.). There is great satisfaction in crossing an item from your "to do" list (remember when you go to the supermarket!).

PUBLICATIONS

As first author you will be completely responsible for writing the manuscript and dealing with the reviewers' comments. You can ask for recommendations from other members of the team and

make modifications accordingly. In preparation of your first 4 or 5 manuscripts please take advantage of Voltaire's wonderful advice: "Perfect is the enemy of good!" Excessive emphasis on getting the perfect paper will frustrate you, your team members, and delay or kill the paper. *Analysis paralysis* is another way of pursuing the perfect in detriment of the good.

> ***"Perfect is the enemy of good."***
>
> **Voltaire**

With regards to publications, it is always useful to try the best possible journal first. It is also important to never become discouraged by negative reviews. A peer review is simply the opinion of the peer about your paper. You should take advantage of all the comments that might make the manuscript better and immediately submit to another journal.

It is very likely that if a proposal that you write gets rejected by drug companies and granting agencies, it is simply too original and ethical, and you should never consider that type of rejection a major blow.

It is very important that you understand that you will be defined by your publications and not by the grant money you bring in. However, your bosses will benefit from the indirect support your grant brings and will continuously encourage you to submit new grant applications. Many investigators spend most of their time writing grants, which prevents them from publishing their findings until it is too late and many other groups have already published them. It is important to apply for funding to support your research efforts, but not to make applying for funding the most important aspect of your academic career.

I always advise junior investigators to keep a balanced investment portfolio of research studies:

- Short-term studies: retrospective, case reports, qualitative, brief surveys. These are the safe studies because the results overwhelmingly depend on you. They will allow you to have items that you can add to your CV every year.
- Medium-term studies: prospective and control, case control, systematic reviews, larger surveys. These projects are also relatively safe. However, they require much more time and you may not be able to put any of these on your CV in a given year.
- Long-term studies: randomized controlled trials, multicenter studies. These are true junk bonds. They will need considerable amount of effort in preparing grant applications, they will require several years for completion, and there is great risk that there might be logistic difficulties out of your control.

If you focus only on the long-term projects you risk having nothing to show for a number of years, and when the time comes for promotion or you want a new job your CV might look quite empty. On the other hand, if you only focus on short- or medium-term studies you may be seen as a superficial and unfocused investigator. The ideal mix is to always have a combination of short-, medium-, and long-term projects. Because clinical research has a trend to happen in moments of more activity followed by long waiting periods to get responses from institutional review boards, granting agencies, etc., it is always wise to have five or six projects going on at any given time. Once you complete a short study it is wise to replace that by another short study; the same can be said about medium- and long-term studies.

THE LITERATURE MINEFIELD

It's important to know that the vast majority of randomized controlled trials are influenced directly or indirectly by industry. Industry-paid studies are positive almost 80% of the time and other studies are positive only half of the time. Therefore, who pays for the study is one of the main predictors of success!

A lot of systematic reviews are simply reviews of studies that have the same bias as randomized controlled trials.

Some of the most meaningful research I have read, and that we have conducted, has been the result of retrospective studies and short prospective studies. On the other hand, many groups continuously publish studies on one more new slow-release opioid, one more rapid-onset fentanyl, and other "me too" drugs with very limited impact.

Please remember that if you have an academic appointment the old aphorism *publish or perish* is true:

- Always publish preliminary data.
- It is sometimes useful to publish a review after submitting a grant application since you've already read and summarized key findings in the literature.
- Try not to present a poster or slide session without completing a manuscript at the same time; this will prevent you from needing to reanalyze and rewrite your data a second time.
- The team is the most important secret for a successful research project.
- The vast majority of the projects that fail do not do so because of poor science or poor design, but rather due to logistics problems; therefore, good administration and maintaining a positive and enthusiastic environment for the research team is one of the most important things you can do.
- There are many palliative care studies you can do today.

13. TEACHING/LECTURING

Most of us have long-lasting memories and gratefulness for inspiring and caring teachers. Most of us owe our career choice and success to these teachers.

There are many reasons for you to become involved in teaching, even if your primary job is clinical.

Advantages of Teaching

- You will learn a lot about the subject you teach.
- It provides variety from a purely clinical and/or research activity.
- It prevents burnout.
- It is necessary and important for academic promotion.
- It increases your visibility, and that of your institution.
- It helps you network with colleagues.
- The process of helping others learn is rewarding to those who teach.

HOW CAN YOU BECOME INVOLVED IN TEACHING?

In some cases it will be a requirement (i.e. medical school jobs). In most cases you simply have to offer giving a lecture to a local hospital grand round or a group of your colleagues, or to submit a proposal for a lecture or workshop at a regional or national

conference. Since there are many live and recorded lectures online it will not be necessary to travel unless you prefer to do so.

Travelling occasionally for lectures (giving or receiving them) is a wonderful way of fighting a routine, recharging your intellectual batteries, learning new concepts, and making long-lasting friendships. It is important for all of us to try to do that at least once a year. It is time and money well invested.

DEMYSTIFYING TEACHING

As is the case for playing soccer or guitar, a minority among us are gifted teachers who need no training at all. The vast majority of us will do a good job and have fun with some minimal training. And yes, a small number among us face major psychological distress or technical difficulties associated with teaching, and will need considerable coaching and formal training. If your career plans require you to do a lot of teaching, especially to more challenging audiences such as undergraduates, you will benefit from some formal training in the form of courses, or even masters or doctoral degrees.

The rest of us do not need such a level of training. If you have a mentor, they can be useful by attending some of your talks, giving you constructive criticism, and coaching you in the areas where improvement is necessary.

One way I learned was by attending lectures and observing the specific techniques applied by the lecturers that I found most educational. It is useful to occasionally attend a lecture and pay no attention at all to the content of what the speaker is saying, but rather focus on the style they are using in the delivery of the lecture. It is also useful to observe the reaction of the participants.

Make sure to ask for feedback about your lecture from colleagues you trust and who are themselves good teachers. They might find simple changes you can make in the content or style of your lecture.

HOW TO GIVE A LECTURE

It may be useful to discuss potential subjects with a mentor or trusted colleague, as well as the outline for your presentation. My experience is that shopping lists are very helpful in identifying all steps that need to be completed before the lecture is ready. It is helpful to ignore the deadline and to start putting a little bit of time each day into the task of preparing the lecture.

With regards to finding a subject, if you are involved in research or publications that is always the best subject. If there are no areas in which you are actively involved in research it is useful to choose a subject you already know and have been thinking about. It is not a good idea to give a lecture on a subject that you don't personally like because you will find it hard to show enthusiasm to the audience.

Once you choose your subject the second point is the content. To decide on the content, including the outline of the presentation, it is important to understand the audience (will they be researchers? clinicians? administrators?). If it is a mixed audience it is always wise to have a mixed content that might be interesting to all audience members.

You need to know the time and duration, and always prepare something shorter than your allocated time. Audiences are always grateful for a shorter lecture and rarely ever grateful for a lecture that extends its allocated time.

> ***"The good, if brief, is twice as good."***
>
> **Baltasar Gracián**

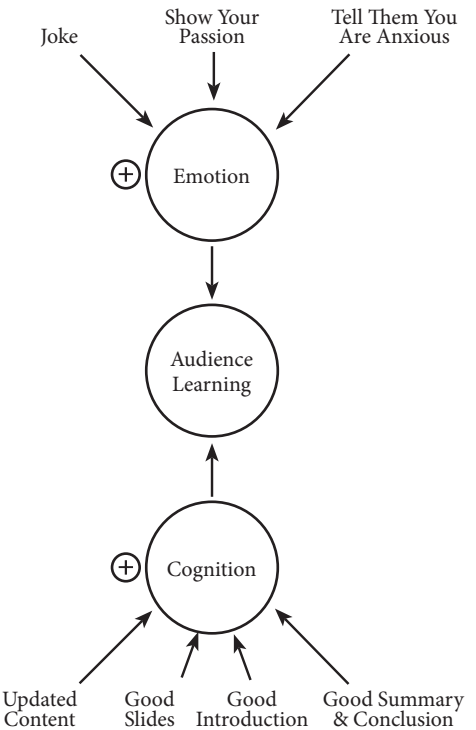
The vast majority of those who will present a lecture will have some level of anxiety. This is completely normal and actually beneficial to the success of your preparation and delivery of the lecture. The main source of anxiety is concern about the reactions of the audience.

It is not useful to prepare or deliver your lecture defensively. You should always prepare and deliver your lectures thinking about those who want to learn and never about potential detractors. That will help you connect to your audience.

It is not necessary to enjoy giving lectures. You might reframe this as a part of the job that is necessary, just like it is necessary to be on call.

Since most of us are not naturally gifted at giving lectures it is very important to rehearse the lecture. Nowadays, it is quite easy to video and time ourselves with the telephone (remember the rule of always lasting less than the allocated time).

The following figure shows that the general learning of an audience happens as a consequence of cognition and emotion. It is important to convey both to create an environment where learning will happen.



Your lecture will be off to a much better start if you are introduced by someone who is able to "talk you up" by emphasizing your skills and your knowledge about the subject. If you are not introduced by anyone then take a few seconds to introduce yourself and what you have done that will help the audience understand why you are an expert in this subject. It will also help to state why you care very much about this particular subject.

It is useful to provide a brief thank you to those who invited you and if you feel comfortable, tell a joke to relax the audience.

If you present in a foreign country, saying just a few rehearsed words in that language at the beginning of your lecture will break the ice and make the audience comfortable with you.

It is very important that you try to find common ground, particularly in areas that might potentially be controversial. Rather than starting your talk by saying that you are for or against a certain clinical procedure, assessment, etc., it might be very useful to start by stating what you stand for, including the comfort of the patient and the well-being of the family.

During the preparation for your lecture it's very useful to spend quite a bit of time preparing the first sentences.

It is important to let the audience know what you want them to learn today, and this requires you to find the message you want to deliver. The old adage says, "Find the message first and the words will follow."

Remember to keep it short!: Baltasar Gracián said, "The good, if brief, is twice as good."

Follow PowerPoint, but never read the PowerPoint. The audience reads much faster than you talk, so pointing and maybe highlighting a word or two of the sentence in PowerPoint might allow them to follow along with your presentation. As much as possible, try not to read your presentation, and ideally do not use cards or cues.

It is important that you show your passion for the subject and your energy in delivering the lecture since this will help the participants learn. This is in contrast to showing passion for one side of a controversy. You should show passion for the subject along with objectiveness and empathy for both opposing views. Remember that you are lecturing for the whole audience.

If it is possible, try to make eye contact with the audience and feel free to gesticulate to accompany your statements.

Your slides are a very important part of your presentation. Some points to consider:

- Avoid long titles
- It is better to have more slides with less text per slide
- No full sentences
- Minimalist: No distractions such as excessive coloring, paintings, etc.
- Some, but not too many, funny cartoons may be useful

If you present tables or graphs, make sure that you guide the audience with your laser or the mouse to minimize the time required for them to understand the table or graph. As a rule of thumb, if it takes you more than a minute to explain it, delete it. With regards to humor, it can generate a positive attitude towards the speaker. Self-deprecation appears to work the best. It is better to use some humor throughout the lecture, rather than only at the start. There is evidence that humor and wit can improve a person's memory of the lecture content and the processing of information.

At the end of your lecture you should provide a summary of your main points as well as a short vision of the future of the subject you are discussing.

If possible, choose a smaller room with more people rather than a half-empty larger room. Using a small podium, or not one at all, creates less distance between you and your audience.

Leaving the lights on throughout the presentation is very useful.

Try to provide space for a standing audience since some individuals nowadays prefer to listen to a lecture while standing.

Never talk for more than 45 minutes and (once again) remember to keep your presentation shorter than your allocated time!

There are some ethical aspects about giving a lecture. It is important to show respect for the audience rather than for the sponsor or the organizers. When you prepare and deliver the lecture you should primarily have in mind the benefit of those who attend and want to learn. It is also important to clearly differentiate opinions from data and to refrain from presenting or discussing wrong data. Avoid plagiarism by never presenting ideas or findings of others as your own.

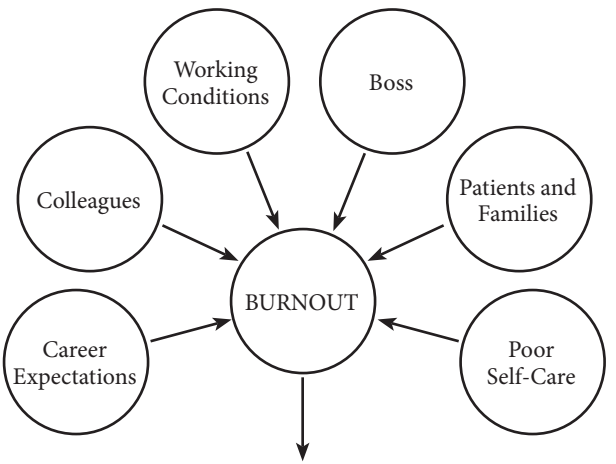
Finally, the fact that we are given the opportunity to lecture should not be an opportunity to engage in derogatory comments against colleagues who may have different opinions from yours.

Giving lectures is a wonderful way of learning a subject, networking and building friendships, getting to travel and visit new places, and once you have done it enough it can be real fun. Perhaps what I find most attractive about giving lectures is the ability to empower other colleagues with the knowledge and the well-being they need to improve their own practice and help patients.

14. TAKING CARE OF OURSELVES AND OUR LOVED ONES

Unfortunately, our undergraduate and graduate medical education has not focused on ways to take care of ourselves, and medicine is facing an unprecedented problem with physician burnout.

Christina Maslach has done wonderful work on the nature and mechanisms of burnout and she identifies three main components of burnout: emotional exhaustion, a sense of lack of accomplishment, and depersonalization.



The accompanying figure summarizes some of the main reasons why we may experience burnout. The two most common reasons are the working conditions and our direct boss. However, some of the other ones identified in this circle can also be major contributors to burnout. Unattended, burnout can lead to serious health consequences including depression, excessive use of alcohol, use of drugs, family conflict, and overall poor quality of life.

It is important to understand that burnout is quite different from finding some activities frustrating and tiring.

I am concerned when a mentee expresses frustration because they are not having fun. It is important for all of us to understand that one of the reasons why we are getting paid is because a significant number of the things we are asked to do every day are not fun. Our opportunity is not to avoid becoming tired, frustrated, or anxious at work, but to be convinced that such effects are justified and meaningful. Finding meaning in our effort makes most of our suffering quite bearable. Viktor Frankl, in his amazing book *Man's Search for Meaning,* taught myself, and many others, that finding meaning is extremely important for resilience.

If the primary team waited until the patient was in the ICU before making a referral to your team; if a referral is called at 5pm although the patient was admitted last night; if this is your fifth consult today—all of these circumstances can be quite frustrating. You will find meaning in all of this work because you know that you will be seeing a patient and a caregiver who are greatly suffering and that you will be able to make a very significant difference in their suffering; this allows you to ignore much of the circumstantial noise. You may also find meaning on being on call at night or receiving phone calls during the middle of the night if you know that your intervention at that point will help the patient and the nurse who is working that night in the hospital.

There is meaning in presenting a research proposal to the IRB, and dealing with grant or paper rejection and resubmission if you believe

that the published paper will educate thousands of readers and help your academic advancement.

There is meaning in giving a talk to a half-empty and uninterested auditorium. I learned this in a frozen, almost empty auditorium when I attended a lecture on palliative care by Dr. Vittorio Ventafridda. He was a globally-recognized expert and there were only four of us sitting in this gigantic auditorium. He gave a passionate and brilliant lecture and I exited convinced that this was the area where I wanted to spend the rest of my professional career. I always remember that lecture as a reminder that I never know if within a small group there is someone who will make a career decision, and perhaps a contribution, based on my talk that day.

Finding meaning is very important as a way of coping with the pressures at work. However, the working condition, the boss, and the other elements we previously presented in the figure can make our work experience quite unbearable, and in that case changing jobs can be very wise.

Before you change jobs it is very important to understand if there has been a change in one or more of the elements you see in that figure. If none of the elements have changed substantially and you are now having great difficulty coping with your job, there might be other personal or family reasons contributing to your symptoms. If these issues cannot be resolved in a way that will allow you to go back to enjoying your current job, it might be appropriate to take some time off or even find a job that is considerably less demanding. However, identifying the causes for your distress is very important to avoid making errors in career decisions.

WEEKLY SELF-CARE

The following list contains 13 activities that you might find useful to improve your well-being each week. Many of us review this list on a weekly basis. A completely successful week would be defined

as having accomplished 8 or more of these 13 items, partial success would be defined as accomplishing 4 to 7 out of the 13 items, and if you only accomplished less than 4 out of the 13 items last week – there is always next week!

1. Exercise most days
2. Healthy food most days
3. Practiced meditation, yoga, mindfulness most days
4. Literature reading (no junk reading)
5. Art, Movie/Theater (no junk movies)
6. Watched visual arts
7. Met with family members in person
8. Met with friends in person
9. Participated in spiritual/religious activities
10. Palliative Care professional education activity
11. Avoided noise most days (TV, sponsored web, work phone after work)
12. Avoided at least one personal item of maladaptive coping
13. Achieved at least one personalized self-care goal

DAILY SELF-CARE AT WORK

In addition to the previously discussed weekly self-care measures, there are many activities you can do daily during our working hours to reduce stress and improve your well-being. I try to adhere to as many as possible of these measures (and yes, that includes a short nap at least once a week!).

1. Movement

- There is strong evidence that standing and moving at work is much better than sitting.
- Walk as much as possible, including during some one-on-one meetings.
- Use stairs, especially if you are only going 1 or 2 floors up or down.

- Stand while you review patients' charts, dictate or write notes, and make phone calls.
- Try to stand during educational activities such as Grand Rounds or Fellows Rounds.
- Try to only sit when visiting with patients or during family conferences.

2. **Nap Time**

   There is very strong evidence that a 15-minute nap can restore physical and mental energy, improve cognitive function, and help with the commute back home.

   - Find a quiet place, ideally with limited noise and light. It is useful to bring with you an eye mask and also a sound system with white noise or soft music.
   - Ideally, set an alarm for approximately 15 – 20 minutes. Naps that are longer than ½ hour are frequently followed by some refractory period that makes us sluggish for about an hour after.
   - Make sure to disconnect your pager and telephone to avoid potential disruptions to your rest.

3. **Hydration**

   There is data suggesting that most of the American workforce becomes dehydrated at some point during the day. This is frequently associated with fatigue and reduced productivity.

   - The ideal fluid is water.
   - All drinks that contain caffeine are diuretic and they do not contribute to hydration.
   - A very clear urine color is a very good measure of the level of hydration.
   - Thirst is a very late and unreliable measure of hydration.

4. **Time Out**

   There is evidence that brief periods of time out in moments of significant stress have great ability to restore calm and improve cognitive function and productivity.

   - Choose a time-out activity that suits you the best: prayer, meditation, drawing, painting, breathing exercises, yoga.
   - A short walk in a green area or close to water has been found to reduce stress.
   - Time-out periods of approximately 15 minutes are usually effective.
   - Make sure that you put all your attention on the time-out activity and avoid distractions during this period.

5. **Ask For Help**

   There is good evidence that supporting each other dramatically reduces the sense of isolation and stress in the working environment.

   - When you have several patients waiting to be seen it is very useful to ask one person in particular to take on one particular patient so as to reduce your burden.
   - When a patient becomes unexpectedly challenging and the visit becomes long, make sure to ask for help with the remaining patients so you can provide full attention to this particularly problematic situation.
   - It is frequently useful to return the favor on the same work day once the burden has improved.

6. **Offer To Help When You Are Not Busy**

   There is good evidence that acts of kindness improve the immune system, mood, and overall well-being in those who perform those acts.

   - If you find yourself less busy, offer help to a person that appears to be under particularly high levels of pressure.

- In days when it is clear that there is unusually high patient flow, offer to take some extra work.
- During difficult situations, such as one or two members of the team being ill, hurricanes, and other unusual situations, offer your help if it is possible for you to participate.

7. **Play Some Music**
   There is good evidence from our group and multiple others that music has a very positive impact on our mood and our productivity.

   - Listen to your favorite music using a portable device while completing your histories, reading, or when waiting to meet someone.
   - Listen to music while walking to different places in the hospital.

8. **Eat Light**
   There is strong evidence that heavy meals, especially those containing a large amount of saturated fat and animal protein as well as rapidly absorbing carbohydrates, result in fatigue, sedation, and reduce cognitive and physical performance for several hours.

   - Vegetables and salads accompanied by a considerable volume of water can be useful.
   - Having 2 small meals during the workday rather than 1 big lunch might be useful.
   - A small meal might be a wonderful time to socialize with friends and colleagues and can also be used as part of your time-out activities if you are mindful during the meal.

9. **Debrief**

   There is evidence that debriefing after very stressful encounters can reduce stress.

   - Discuss with a colleague what went well or wrong in the encounter.
   - Expressing feelings is very useful.
   - End with a plan, including involving someone else in the care plan to prevent further stress.

15. INTEGRITY

A medical career is neither simple nor fair. I wish I could tell you that only those who display strong ethics will ultimately achieve recognition and power. However, you will see many colleagues achieve great power, and academic and financial success with total lack of integrity. Many major medical leaders are narcissistic and/or have antisocial personality disorder. On the other hand, many of my medical and academic heroes, the ones whose example guides my behavior, are not famous or powerful.

In my experience there is not a close correlation between integrity and success.

An ethical professional life is ultimately a personal choice you will need to make independently of its career advantage, and it's much more related to your values. The following figure summarizes some of the advantages and disadvantages of behaving with low integrity.

ADVANTAGES

- Personal Financial Gain
- Faster Academic Advancement
- Powerful Interests Will Promote Your Career
- Other Low Integrity Colleagues Will Seek Associations With You

DISADVANTAGES

- Patients and Colleagues Will Be Hurt
- You May Violate Regulations or Laws
- You May Lose Respect From Colleagues, Friends, Family
- You May Lose Self-Respect

There are a large number of circumstances in which you will be at risk for conflict of interest. Some of those include the following:

- Relationships with the pharmaceutical industry to author papers where they had control of the study design, execution, and data management. Frequently, these studies end up published in high-impact journals.
- Invitations to lecture for industry, including in some major congresses, for excellent honorarium.
- Invitations by Electronic Health Record companies to implement their particular system in your institution.
- Invitations by companies who profit from Maintenance of Competence guidelines for physicians.
- Conducting clinical research or education on drugs, devices, or tools where you have a patent or copyright.
- Invitations to advocate for the interest of health insurance companies in guideline committees or quality committees.

- Invitations from hospitals and other care providers to develop guidelines oriented towards financial benefit rather than patient well-being.

In some cases it may be possible to resolve some of the conflict and have some level of collaboration. If this is not possible the best course of action for you would be to respectfully abstain from participating in these activities. I spent all my professional life in an environment where disclosing conflict of interest was all that you needed to do. Disclosure does not eliminate the bias in your lecture, committee participation, or research study.

You should always try to avoid working for a low integrity boss. These individuals are likely to behave with low integrity towards you and your professional development. Since they are frequently involved in practices that are borderline you may become tainted by collaboration with them. In addition, you will be at risk of some of the responsibility being transferred to you if things go bad for them.

In some circumstances it will be impossible for you to avoid having to work for a person with low integrity. If this is the case, one important consideration is to keep careful notes of your interactions and periodically send back polite e-mails summarizing your understanding of your agreements. This will be important protection for your credibility and career if things do not go as planned.

It is quite possible to have a successful career in most settings without needing to become part of low integrity practices. Early diagnosis of areas of high risk will allow you to prevent exposure to situations that might permanently damage your personal credibility.

16. CONCLUSIONS

I have spent all my professional life within the biomedical/industrial model. Medical school deans, hospital directors, federal and philanthropic granting agency leaders, and healthcare authorities have been educated within this model and they mainly reward those who fit.

As I write this book, and for years to come, this model will continue to dominate medicine.

Physicians who have passion for patient- and family-centered care face lower income, less employment stability, weaker administrative structures, less research support, and overall less administrative and academic respect within this environment.

Liliana De Lima, who made a gigantic contribution to our field, brought to my attention these wonderful words from Dr. Martin Luther King Jr. about a segregated society: "It gives the segregator a false sense of superiority and the segregated a false sense of inferiority."[5]

A lot of what you do is poorly understood by those who were born and raised within organized medicine. These individuals are not bad. They went to medical school with you and they have

5 King, ML. "Letter from Birmingham Jail." 16 Apr. 1963.

the same level of idealism, and they hope for a better future as we all do. They are also not less smart than us.

The main reason why they have a false sense of superiority about what they do and a false sense of inferiority about the complexity, and intellectual and humanitarian challenge, of delivering palliative care is that they have not been educated about it.

Fortunately, as my favorite Nobel Prize winner said, "The times they are a-changin'."[6] As my career enters its final stretch, I am very optimistic about a much better future for those of you who are considering patient-centered care. A new generation of leaders is emerging that gives much more value to the care of the person, and at least some of them are doing it in a palliactive way.

Please never feel inferior for believing in this field and do not fear for the future, because it looks brighter than ever before.

I really hope you will decide to join us in the wonderful world of palliative and supportive care. I also hope this short book will make the road ahead a little less bumpy. Godspeed ahead!

6 Dylan, B. (1963) The Times They Are a-Changin'. On The Times They Are a-Changin' [Music Album]. New York, USA: Columbia Records.