

Correspondence

Interpreting Toxic Intern Syndrome

TO THE EDITOR: As a medical school graduate of 33 years and a physician in private practice for 24 of those years, I take strong exception to Dr Dyer's conclusions in her commentary in the April issue.¹ My interpretation of her basic conclusion is that we are either stuck with a terrible system—her description—or we must bring unlimited resources to have something more to her liking. She yearns for the coming years of private practice or an academic life. I have news for her. It gets worse. She will be called increasingly to spread limited resources among unlimited demands for them. The whole thesis of managed care is to justify and limit requests for health care. Physicians have to learn where their efforts will be of benefit and push hard in that area while realizing that not everything can be done and that with some patients, much effort will go for nought.

I hope that Dr Dyer survives (or has survived) her internship and will go on to enjoy medicine in this less than perfect but still very interesting world where she can make a difference, even if it is not as great a one as she would like.

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REFERENCE

1. Dyer KA: Toxic intern syndrome. *West J Med* 1994; 160:378-379

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Dr Dyer Responds

TO THE EDITOR: I was surprised at the dichotomous reaction to my article. On the positive side, my fellow interns, residents, and hospital staff generally agree with the sentiments I expressed and claim that I have captured the "internship experience." They appreciate that someone has finally put into writing the common feelings of a resident's daily life. One of my former residents, now faculty, plans to make the article required reading for his medical students. I have also received letters from other physicians who assure me that things do get better in private practice.

On the negative side, I have been questioned as to whether I should even have gone into medicine. Upon returning to the Veterans Affairs hospital I was asked, "How can you work here when nothing has changed?" Another physician told me, "It's not a toxic intern syndrome, it's reality." I find that those who react negatively to my comments are misinterpreting them or missing the point.

I wrote "Toxic Intern Syndrome" at the end of my year of training in internal medicine in Fresno to gain some perspective, put into writing what was going on around me, and start questioning the process.

The issues I raised are those faced daily by house staff and primary care professionals who contribute the bulk of the medical treatment in many areas for the homeless, indigent, veterans, and immigrants. My purpose was to get people to take notice, to remember and begin thinking

about the problems. I hope that someone else reading the article will find the solutions to the problems. Without questioning there is no change.

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The Ethical Versus the Legal

TO THE EDITOR: Dr De Ville's commentary in the May, 1994, issue¹ makes the point rather well that ethical and legal issues should be separated when discussing a bio-ethical "hard case." The difficulty comes when a case progresses from discussion to action. Physicians, being men and women of action but needing to abide by the law, are bound to ask the legal limits of what actions they may take in a given case. Ethical limits are generally too fuzzy to serve as a guide to action in today's litigious environment.

Consider as well the relative incentives and penalties for taking a clinical course of action that could be unethical or illegal. Besides high self-esteem—not usually lacking in physicians anyway—and (maybe) the respect of patients and peers, what tangible reward is there for making an ethical decision in a tough case? What serious penalty is likely to follow an unethical, but legal, course of action?

In contrast, imagine trying to defend a physician in today's courts for doing the right thing ethically while knowing it might be illegal. Keep in mind the ethical compromises physicians must make every day while trying to provide good patient care in a cost-contained, resource-limited practice environment. Do not forget the second-guessing by a plaintiff's attorneys and expert witnesses who have had months to analyze a decision that a physician had to make in a matter of minutes.

Of course it is important not to mistake law for ethics and vice versa, but if you are on a hard case and you are not sure what to do, which mistake would you rather make? That is why I will still want to know, "What does the law say?"

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REFERENCE

1. De Ville K: 'What does the law say?'—Law, ethics, and medical decision making. *West J Med* 1994; 160:478-480

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Dr De Ville Responds

TO THE EDITOR: I appreciate Dr Nicholson's thoughtful letter and believe that his comments will find much support.

Given the present state of medicine and law, it is important that physicians know what the law says about relevant aspects of their work; however, an overreliance on "what the law says" tends to taint both clinical decision making and ethical reasoning. For example, a medical

staff gathers to discuss the situation of a profoundly ill and permanently injured neonate. The attending physician (or ethicist, or staff attorney) begins the meeting by writing the federal and state "Baby Doe" regulations on the blackboard. The ensuing discussion has now taken on and is dominated by this legal frame of reference, the unstated assumption often being that this framework is primary and replaces or trumps the "best interest standard." Legal approaches to problems engender habits of mind that are profoundly difficult to overcome.

I would suggest only that ethics committees, medical staff, and individual practitioners defer discussion or consideration of the legal aspects of a case until they have concluded their clinical and ethical deliberations. At that point, if there are relevant legal considerations, the decision maker can face squarely and honestly whatever conflicts arise.

Dr Nicholson reminds us that physicians are "men and women of action" and require guides to practice. Ethical limits, he argues, are too "fuzzy" to serve as such guides; he would much prefer to rely on legal guides. This position appears to assume that legal guides and standards are not fuzzy. From my experience, there is very little that is definitive or clear about medical jurisprudence primarily because medical law, like medical practice, is very much a case-by-case endeavor. More often than not, when I tell medical professionals what "the law says," all I can tell them is maybe. This frustrating level of legal uncertainty is all the more reason to suggest that legal reasoning and concerns should play a highly circumscribed role in ethical deliberations.

Dr Nicholson also argues that legal penalties are more onerous than those imposed for ethical violations. Perhaps. I believe, however, that most physicians are in the profession to do the right thing—to help their patients. They have a personal, moral commitment to their calling.

To many practitioners, the greatest penalty of all is to be robbed of one's professional identity by focusing on what one believes the law says instead of what one believes is proper and ethical care. And, these losses are ones against which no one can insure. Dr Nicholson suggests that juries would be much more sympathetic to physicians who follow the dictates of the law than to those who do the right thing. He may be correct, but it is not obvious. It may sometimes be quite difficult to divine the correct or safest legal posture prospectively. Moreover, there is substantial evidence that juries attempt to dispense a form of rough justice, frequently straying from the technical dictates of the law to reward or at least protect those defendants who do the right thing.

Dr Nicholson's comments regarding the relative penalties for illegal and unethical behavior raise another interesting problem. Self interest (in the form of self protection) is a legitimate consideration when choosing among various alternative courses of action. This observation is true in medicine as well as in other areas of life, even though physicians have limited the role of self interest somewhat by pledging to act in the best interest of their patients. But the existence of self interest as a motivating factor in decision making does not alter the essential content of one's ethical duty or of the relevant legal mandates. It merely plays a role in determining how fully physicians will comply with what they see as their ethical and legal duties. Having worked in a medical malpractice defense office, I understand that physicians have a personal need and a professional right to take some protective measures. It is imperative to remember, however, that one's choice of protective measures is itself a vexing ethical problem.

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