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White Coat Ceremony
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Thank you for having me. To Cheryl McPherspon who invited me and to many others here who helped with arranging things, thank you for welcoming my family and me so warmly. It is a treat for me to have my wife, Juliet and two children, Jonathan and Emily, here listening to me today. Whether it is a treat for them....we'll see.

To the medical students assembled today, congratulations on being here. You have chosen a profession that is endlessly fascinating, occasionally frustrating and always fulfilling.

To the families of the medical students, you have much to be proud of and you have much to offer your children in the coming months and years and decades: the experience and wisdom of parenthood and the stability of having known each other for decades.

To those of you who are the spouses and boyfriends and girlfriends and friends of any sort to the medical students, some here, many I imagine not, you also have important things to offer: you will be companions during the latest of nights and earliest of mornings and during the many joyous and sad times. Your support will mean more than you can know.

This is not an abstraction: I say these things as a son and a husband more grateful than I can ever say to my own wife and parents and now my own children.

I would be remiss in not noticing that this is a little bit of a challenging time to give a speech of any sort: on Monday, at a Martin Luther King Day celebration in Chicago, I heard excerpts of some of Dr. King's speeches; the next day, I and I'm sure many others in this room heard the inspiring inaugural address of President Barack Obama. President Obama's address was followed by a benediction from Reverend Joseph Lowery who marched with Martin Luther King and whose quiet passion moved many of us to tears. Whether you are a Democrat or Republican, from the United States or Grenada or another country, this is a time of great challenge, change and hope in our world.

I mention this not to make this talk into a political address, but to reveal a little of my own anxiety at giving it at this time and to plant in all of our minds the importance of the social and political context in which we find ourselves. More on that later.

Finally, as someone who never went through a white coat ceremony myself, I must confess to feeling a little like a pretender here today.

I am, however, someone who has worn a lot of white coats and still does. Each of these has certain associations for me – the one I wore as a medical student whose pockets sagged under the weight of the books and instruments and was always too clean and a little too white; the one I wore as an intern and resident whose pockets bulged with

endless to do lists (not always completed) and which never did seem to get very clean or white enough; the longer one I wear now as a palliative care physician with more than a few stains from the Chicago slush kicked up on the four block walk between my office and the hospital.

I still have some of those early white coats in my closet. During my time in medical school, we got one official one at the start of first year (not in a ceremony, but in a bag) and then it was a little bit of a friendly competition between us to see how many we could get from the different hospitals we rotated through. We were supposed to return these at the end of each rotation and we rarely did: given our tuition costs, I calculated that we were actually paying 10s of thousands of dollars for each of them and that lessened my guilt over taking them.

One of these coats from my days as a medical student recently had a second life on the shoulders of my son, Jonathan, who wore it for a play. He wore it not as a doctor but as a mad scientist – a use that might have surprised the original owners of the coat at Mass. General Hospital but made the current owner, me, very proud.

As I was preparing this address, I did a few things.

First, I tried to think back to my medical school admissions essay: that must have had something about my hopes as a future physician; that could help put me in the shoes of those of you here today. Unfortunately, when your filing system consists mostly of

horizontal piles and cardboard boxes, as mine does (my wife is smiling broadly right now), finding such a thing is a bit of a challenge. No worries, I thought, there must be an electronic copy....there no doubt is, locked on something called a three and half inch floppy disk that we used to insert into the original Macintosh computers that came out just as some of you were entering not your pre-med years, but your pre-school years. And some of you had not entered any years at all. For those of you who are curious about these computers or like me, nostalgic about them, they can often be found on eBay, reconfigured as fish tanks or planters.

But here's what I imagine I wrote about and here's what I imagine many of you wrote about: wanting to be caring and compassionate and wanting to combine a love of science and a love of people. Those are noble values for all of us and I mention them not to diminish them, but to celebrate them.

I want to use my time here today to project ahead with you past your years in medical school and in residency and think together about the values and the habits that I hope will sustain you as they have me in this profession. This is important because while it might seem like a long seven or eight or nine years of medical school and residency, it is actually a relatively small percentage of the 30 or 40 or 50 or more that you will spend as a physician.

The second thing I did as I started preparing this address was look at how others have thought about the white coat ceremony. This is a habit that I have developed over the

years (and one that you will soon develop if you have not already): whenever I have a new project or a new talk or a new paper to write: Look in the literature: Go to Medline, go to Google, go to your own piles of papers and see what others have had to say: it will help frame your own thoughts, it will give you perspective and, of course, it can be a great procrastination technique.

This second activity had a curious parallel to my first activity of trying to find my med school essay. In the same way that I could not find that essay, I could not find much that resonated with me in some of the published literature about the white coat ceremony.

Here's what one commentator said. You will see in a moment why I do not identify him.

“The short white coat can be a highly useful tool allowing patients to identify practitioners in a liminal state. However, by officially sanctioning the white coat as a sign of the psychological contract of professionalism and empathy, the medical establishment may be responding to abrogations of its own authority and is teaching students that they are respected for their sartorial behavior separate from their behavior as individuals.

Conclusion: The White Coat Ceremony fosters a sense of entitlement whereby authority based on title and uniform, and authority based on trust, are poorly distinguished.”

“Authority?”

“Liminal state”

“Entitlement”

“Abrogation”

“Sartorial behavior”

It all sounded a little abstract to me: more like an undergraduate philosophy class than something relevant to medical students and physicians. And that part about “sartorial behavior” sounded like it had something to do with a tuxedo or a ball-gown. Perhaps something from an inaugural ball.

So I turned to another source, Robert Veatch, whom I know comes to St. George’s to teach ethics. Dr. Veatch is as impressive a thinker and writer as there is in bioethics and he is not someone who shies away from controversy. He wrote one of the first textbooks of medical ethics I ever read.

Here’s what Dr. Veatch wrote:

“The white coat ceremony may be an impressive ritual for the beginning of medical school. It may add an ominous drama to the first days of a student's new career. In the process, however, the ceremony raises serious ethical questions. It is doubtful that any code recitation has any legitimate meaning when that code is imposed on a group of students too new to their profession to understand its

meaning or even whether its content is controversial. It is doubtful that any code recitation is legitimate if the vast majority of students, when they are better informed and have had more time to think, would really prefer some other commitments. It is doubtful that a "bonding process" is tolerable if its real function is symbolically to remove students from the culture from which they have come."

Well, no more "liminal states" or "abrogation," but Dr. Veatch's words gave me certain pause and I want to tell you why.

First, I hope that this day isn't too ominous for most of you. I imagine it might be daunting, but I hope it's not ominous.

Second, I commend Cheryl and others here for having a ceremony that "raises serious ethical questions," especially when these come from an esteemed visiting professor such as Dr. Veatch: raising questions is one of the ways we all learn and one of the ways we all do better, whether as ethicists or physicians or both. And besides, I bet Dr. Veatch was being a little hyperbolic in his prose.

Third, and most importantly from my perspective, I also hope that this white coat is not representative of an attempt by St. George's or medicine as a profession to "symbolically" "remove" you from your own culture. The best experiences of medicine for each of you will be when you are able to combine aspects of the "culture of

medicine”, however defined, with aspects of your own cultural backgrounds. As a physician with two feet in the culture of medicine, I also have those same two feet planted in a cultural background that pre-dates my becoming a physician. You may want to ask my wife or friends, but I don’t think medicine has removed me from the culture from which I have come.

The third and last thing I did after turning (unsuccessfully) to my medical school essay and some of the literature on the white coat ceremony was ask some people closer to this experience than I am right now. I asked a group of third year students about what the speaker at their white coat ceremony spoke about two years earlier. And what they would recommend for me. There was some hesitation since they couldn’t quite remember at first (not a good sign I thought) and then one of them said: “Progeria.” And the others nodded and smiled. A few even rolled their eyes. Ah...premature aging, I thought, that actually did have a devious kind of relevance...

“So I should talk about a disease?” I asked.

This time there was no hesitation: “No.”

For those of you who came hoping to hear about a disease, whether progeria or any other illness, you have your Northwestern colleagues to thank (or blame).

So, no diseases, relatively few bioethical concepts, and a respectful disagreement with Dr. Veatch about the white coat ceremony removing you from the cultures from which you have come.

What I do want to talk about is *my* experience of the symbolism of this white coat. As I do this, my larger goal is to help all of you project 10 and 20 and even more years into the future to see what will sustain you in this profession.

I will take as a foundational element of medicine and becoming a physician that caring and compassion and science are all a part of why we are here today.

You will find that the subjects of your caring and compassion will change: sometimes patients, sometimes patient's families, sometimes colleagues and friends and your own families.

You will also find that the underside of caring and compassion will sometimes be just below the surface: you will have moments of anger and frustration and fatigue at all of those groups of people. That's OK, as long as you have a technique to deal with these moments. I will not suggest any today, but I ask you to recognize that these moments will happen; and when they do, seek the wisdom and the shoulders of friends and mentors. Remember what I said in the beginning about families and spouses and friends? These times and feelings are expected and will only fester if you do not find ways to share them.

The subjects of your science will change too: whether by organ system or by year of schooling. Make science a refuge when caring and compassion seem too hard and too taxing. But don't let it replace caring and compassion. Make compassion and caring a haven when the science gets to be too overwhelming and the nerves in the brachial plexus start to blur and you eyelids start to fall. But don't let compassion and caring replace the science.

When I was in medical school and got sick of pathophysiology or anatomy, I tried to read something in ethics or politics or something that seemed more about the "caring" side of things. Or I just hung out with friends – that's a form of caring (and being cared for).

When I was tired of hanging out or when the ethics reminded me too much of a strange high-school philosophy teacher I once had, I opened that pathophys book again.

Let me use another example to define what I mean:

I am a palliative care physician and an internist and my clinical work focuses on quality of life, symptom control and support for patients with serious illnesses and their families.

Many of the patients whom I care for are dying and they and their families are facing hard choices and harder days. One of the things that I love about palliative care is that there are often very specific medical things to do and think about – what is causing this patient's shortness of breath? What opioids am I going to use to treat this type of pain?

And there are also opportunities to help patients and families deal with something that I

sometimes call “the big picture.” The big picture is a little bit of a colloquialism but here are examples of it:

What does this illness mean?

What am I going to do now that my husband is dying?

How am I going to decide whether to continue the ventilator?

These types of questions require a lot of caring and compassion from each of us as physicians, nurses and every type of health care professional. Sometimes, though, it is equally important to focus on the biomedical and more concrete question of the physical pain that a patient is experiencing. Indeed, as others have observed and I have witnessed, all the talk of meaning and faith and togetherness in the world doesn't mean much if you are in intense physical pain.

In palliative care, symptom management is the science; helping patients and families cope with illness and dying is the caring and compassion part. For every patient and family and for every physician in palliative care and in any field, the best kind of care and caring will combine both of these instincts: the compassionate one and the scientific one.

An exclusive focus on either will help neither patient nor family nor physician.

Now, what do I want to add to this foundation of caring and compassion and science?

What have been more recent values and habits that I have embraced? Here are five:

Curiosity

A Tolerance of uncertainty

Humor

Passion

And Service

I'll begin with curiosity

Practicing medicine is fundamentally about entering into other people's lives. Sometimes it is through talking such as in a relationship with a psychiatrist or an internist; sometimes it is literally entering into someone's body in the case of a surgeon. Each of these requires skills that can take many years to master: what to ask and where to cut. Said in that way, it couldn't sound more simple, but it's not: how we ask, how we listen, how we react is everything and means the difference between connecting with a patient and perhaps a diagnostic clue and missing a diagnosis or a moment of connecting, just as for the surgeon, how and where and at what angle he or she cuts is the difference between a successful operation and a complication. All physicians, whether internist or surgeon, gynecologist or pediatrician, psychiatrist or emergency medicine physician, require motivation in the form of curiosity: a curiosity that motivates you to want to know about someone's life to dig deeper into their situation or to perfect an operation.

The stories you will hear will amaze you, will surprise you, will sadden you and will inspire you. You will get to hear things about people that they have told no one else: things they are proud of, things they are ashamed of, things they wish they could change.

And you will be entrusted with a lot of secrets. Please treat these with the respect and dignity they deserve.

Why be curious? There are at least two reasons:

One, it can help you diagnose illness. This is most obviously true in the case of psychiatric illnesses, but it is also true for many medical illnesses. It still amazes me how often I find out things about patients' relationships or spirituality that are mediating the pain that they are feeling. That helps me to help them with their pain. So, it can help patients to be curious.

Two, it can help you. The stories patients tell us teach us things about them, make us reflect about ourselves, make us laugh and make us wonder and keep us engaged in this work. And that helps sustain us. The 84 year old patient with COPD and pneumonia becomes much more engaging to you (and you to him) when you find out that he spent his early 20s on a Navy ship in the Pacific before coming back to the States to open up a barber shop. And what's amazing is that this information does not require lots of digging through medical records, does not require many tests. It just requires the instinct of curiosity and the patience to listen.

Let me give you a more recent example from my own life as a physician: I recently saw a man in his 30s with Crohn's disease and terrible abdominal pain who also struggled with depression and addiction. He was a patient who was suffering and one who angered a

number of his physicians, including the one speaking you to you today. He angered us because he was demanding, because we couldn't seem to help him, and because he was never satisfied with our attempts to be compassionate. We were not proud of our anger, but we recognized it.

Each morning we would dread going in the room and we'd be pissed off when we came out. One morning on rounds, I decided to take another tack and asked him about the tattoo on his neck – it looked familiar to me but I wasn't sure why. He reminded me that it was the symbol of a 1980s punk band, *Black Flag*, that I used to listen to. He was a fan of them; in fact, he was a musician himself. And so we spent a few minutes talking about punk music. And all of a sudden we had something to talk about other than his pain. Did it cure his pain? No, but it did make it easier to talk to him; it helped us connect and it even brought back memories for me.

So, be curious: ask patients what they do for work, what they do for fun, what that tattoo means, what symbol dangling from their neck is all about. It actually doesn't take a huge amount of time and it will make you a happier physician.

Let me move on to my second value: A tolerance for uncertainty

Being sick means dealing with many kinds of uncertainty: over diagnosis, over prognosis and over the fundamental question “Why has this happened?” If you think it will be hard

not knowing the diagnosis or what to do as a student or a physician caring for a patient, try to take the next step and imagine how a patient will feel in this same situation.

You will need to join your patients in this uncertainty. You will spend years here and decades beyond here trying to be certain about as much as possible – and that is a good thing. But as carefully and thoroughly as you try to figure out what can be known, what is certain, there will always be things you will be uncertain of. Be there with and for your patients in this feeling. The uncertainty of many illnesses will not change even as diagnostic procedures and treatments improve; it is only the topics of our uncertainty that will change.

Patients don't necessarily want all uncertainty to be erased, but they do want someone to be present with them in that uncertainty. If you cannot tolerate uncertainty, if not knowing exactly what is going on unnerves you, you will not be able to truly be with your patients and your colleagues.

My third value or habit: Embrace humor

Palliative care is not supposed to be funny. Neither are many other medical specialties. They are supposed to be serious and somber. So why can I turn on a TV and find shows like *Scrubs*, *Grey's Anatomy*, *House* and find myself laughing? Think for a moment: How does a network decide a show will continue? It is a very basic calculation: if there is a market, it will happen. And so, people want to laugh about illness (or at least laugh at

doctors). And who watches those shows? Medical students, of course, but you are vastly outnumbered by patients and families. And if they thought that being humorous about medicine was taboo, they would stop watching and the shows would stop airing.

It is precisely because of the awe and awesome-ness of illness and of the situations that we bear witness to that humor is so necessary. If you are open to humor, if you use it wisely with patients and colleagues and peers, it will help you. It may help you connect with a patient, it may help you connect with a colleague, it may help you have a better day – and that is worth a lot.

What do I mean?

Several months ago, I was caring for a man who was dying from heart failure. I met him in the last days of his life on our palliative care unit after his family had decided to withdraw the ventilator that was sustaining him. On morning rounds with our palliative care team, we visited him and his family at the bedside. He was an African American man in his 80s and although he was unresponsive, he looked peaceful and dignified in that bed. He was breathing slowly and his face was relaxed. He was large and muscular with gray hair around his temples and he had the look of someone whose heart failure had come on relatively suddenly: he was not as thin and wasted as many patients with chronic heart failure are.

I asked his family what he had done for work. They told me that he was a preacher at a Church on the South Side of Chicago. He had done that for decades and had many devoted congregants who had seen him in the hospital. We talked about this and his son who was there talked about how he would be taking over for him and the large shoes he would have to fill.

And then I happened to glance at his TV. He was in one of the new rooms on our unit with a huge 42" plasma TV on the wall. Does anyone here have any ideas what is on mid-morning TV in the city of Chicago? There, with the sound off, above the bed of this very dignified preacher, was that day's episode of the *Jerry Springer Show* with the title in bold red letters across the bottom of the screen: "Midget madness" and two dwarves in shorts prancing around a makeshift wrestling ring. The combination of this incredibly dignified preacher and this incredibly exploitative TV show still makes me smile as it did that day. As we left the room, we all laughed as a team. Not in a disrespectful way, but a happy way – it was a moment of levity and strangeness in the face of the tremendous sadness of his dying. And I know that it was partly that glance at that show on TV that makes me remember that preacher.

So, don't be afraid to find humor in the care you give.

Being curious, tolerating uncertainty and embracing humor will all help you respect one of the fundamental currencies of medicine: the stories of the patients and families you care for. These stories are what patients give to you. Your listening is what you give back

to them. But don't just listen: listen with curiosity, with a tolerance for the uncertainty of the situation and with an eye and an ear to humor. As you progress, add these habits to the caring and compassion that brought you here.

Let me end with two other qualities which have helped sustain me and I hope will sustain you: passion and service.

Simply put, have a passion

It can be for discovery, for taking care of patients, for teaching, for something else; just make sure it is yours and make sure you feel strongly about it.

What do I mean make sure it yours?

When I was medical student and spent some time as a pre-medical advisor, I met a student who wanted my help with his medical school application. He wasn't sure what to write his essay about. So I said to him, "write about something you feel passionate about." I remember this moment to this day even though it 20 years ago. I was sitting across from him in the dining hall and he paused and looked at me and he said: "What would that be?" I smiled and told him that if I were to tell him what it was, it would no longer be his.

Let me share something on this from my own life: I feel passionate about teaching. Being a better teacher to students and colleagues, to patients and families, drives me each day. I am not the only one with this passion and all of us will have a setting to realize this passion if we choose to. One of the gifts of being a physician is that you get to teach others all the time. Oh that's just something for physicians who stay in academic medicine you might say. That is not the case: This is true for every physician almost every day of their lives. You will teach patients and families and peers and you will teach your professors. It is the rare professor who does not learn many things from the students whom he or she teaches. If teaching is your passion, indulge it fully and find ways to do it well.

Others of you may develop a passion for a type of research or for a type of procedure or for a population of patients. Some of you may already have. Nurture and sustain these passions and find opportunities to express them.

Finally, A commitment to service

I will end with service since it is very much on my mind during the US presidential transition. It verges on a cliché, but it is something that many of us feel deeply: Medicine is fundamentally the opportunity to serve patients.

But I want to use this opportunity of this white coat ceremony ask you to try to do something beyond the act of taking care of patients, teaching each other and even doing

research that is an act of service. This needn't be big, this needn't be time-consuming, but I urge you to make it something.

Let me give you two examples from my own life to illustrate what I mean.

When I was a primary care physician, every election season I would ask my patients if they were planning to vote and urge them to do so if they were not. I would say "I don't care who you vote for, but I care that you vote." We would both smile knowing that was not completely true: I did care who they voted for, but it was also none of my business. If I got one person to vote who wasn't planning to, I liked to think I did my job in this domain. Involvement in the political process is a form of service. It can take many forms. Asking your patients to vote is easy, free and doesn't take much time.

There are of course, myriad other ways that you can devote time or money to the political process in every town and state and country in the world. Consider finding one of these that fits with your values.

There is also very direct service you can provide as a physician. This can be in underserved communities, this can involve seeing patients, helping raise money, serving food or being a companion. For more than a decade, I have worked one or two evenings a month at homeless clinics in Boston and Chicago. I see patients there whose strength inspires me; whose suffering moves me and sometimes, whose behavior angers me. Luckily, this last category is a small one. Mostly, this activity allows me to help patients

with very basic things: a cough, high blood pressure, a pain in their back or an ache in their neck. Or the need to be heard: To have someone listen to their story, ask a question or two and, once in a while, give advice or validation.

Each of us has been given an incredible and rare gift to be a physician. And for me this is one form of giving back to others.

This is just one example of service: there are many others in many settings with many different types of people and patients. I told my patients that I didn't care who they voted for when I asked them to vote and I confessed to you that I wasn't being completely honest with them. But I will be completely straight with you when I urge you to involve yourself in some kind of community service, large or small, medical or non-medical, directly with patients or not.

You may not feel you have time at every stage of your career and you may not, but you always have time to develop the habit in yourselves to ask: "What ways, beyond my immediate school tasks, beyond my immediate job, am I helping to serve others?" It will sustain those around you and it will also sustain you.

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I have tried to outline a set of values and habits that can build on the compassion and caring that brought you to this point: an abiding curiosity, a tolerance for uncertainty, an embrace of humor, a commitment to be passionate and a reflex to serve.

All of these will ebb and flow in your lives as students and physicians. Do not try to do everything at once, but do try to remember these characteristics in the work that you do over the next decades.

This coat that you are now wearing will give you opportunities to enter people's lives, hear their stories, and help them in small and deep ways. As I said, I hope it represents more (and less) than the "ominous drama" that Dr. Veatch hypothesized. I hope instead that it is a reminder of the diverse ways that you will make a difference.

As you do this work of medicine, you will discover some number of patients and families, role models and mentors who will both inspire you and help keep you grounded. Savor and celebrate those people because they will remind you why you chose this profession and why you will go to work the next day. And turn, always, to your friends and peers and colleagues, because they will help balance you as they already have.

Good luck in your years here at St. George's and good luck in the years and decades beyond, wherever they take you. And thank you again for inviting me here today and giving me the very special opportunity to share some of my reflections on what makes this profession such a special calling.