

CHAPTER ONE

ABILITY

*“The winds and waves are always
on the side of the ablest navigators.”*

-Gibbon

When I arrived in my community 25 years ago, most practicing physicians had experienced no professional contact with an infectious disease (ID) specialist. In fact, at that time the ID boards had only existed for five years. Unless these physicians had interacted with an ID specialist in training, there had been virtually no personal exposure to my field. I had no competition at the time, and I expected to be busy right from the start. Wrong assumption.

I knew what I was capable of doing, but the community did not.

This community had been getting along just fine before I came, and many physicians did not feel that their patients needed my services. After all, virtually all physicians use antibiotics. So what was the big deal about requiring an ID specialist?

Initially, I got some referrals but not very many. In my fellowship at the University of North Carolina there were plenty of consults . . . but not here. I wondered if there were less complicated infections. The surgical community, especially orthopedists, was the first to request my services. Perhaps this was due to the devastating complications of osteomyelitis after joint replacements and open reduction and internal fixations. Perhaps they figured it was a good idea to get it right the first time. Perhaps they realized it would be beneficial to have someone such as myself

supervise a long course (sometimes six weeks) of potentially toxic antibiotics. Nevertheless, the perception of my ability in the orthopedic community grew as more of these colleagues observed my work. Post-surgical osteomyelitis had become my first niche.

But still the majority of practicing physicians were not consulting me.

At one of the hospitals there was a family practice training program. I had assumed that in medical education ID would be more familiar. Again I was wrong. Family practice has essentially no subspecialties, and in this community hospital without any other training programs (except OB/GYN), there were no fellows with whom to interact. I gave lectures to the housestaff which helped a bit, but I still felt that I was not seeing the cases I knew were out there.

All of this changed with my first *resurrection consult*. A forty-year-old African American male, Joseph Wright, had become ill one week after attending a picnic at a local park in town. He had developed fevers to 101 degrees F, severe frontal headache, myalgias, and photophobia. He was given an oral cephalosporin but got worse and was admitted to service medicine. The housestaff obtained cultures of blood, urine, sputum, and spinal fluid all of which were negative. The CSF showed no cells at all. Despite empiric treatment with an extended-spectrum penicillin and tobramycin, his condition continued to deteriorate. Five days after admission he became comatose and developed renal failure. His platelets fell, and he developed a petechial rash on his extremities. It was at this point that I was consulted.

After reviewing the chart I noticed that Mr.

Wright had come in with hyponatremia as well as thrombocytopenia well before his kidneys failed. Moreover, with the history of being in the park the week before, I asked the family about tick exposure. Several people, including Mr. Wright, had indeed pulled ticks off their skin. All of these clues now led to a diagnosis of Rocky Mountain Spotted Fever (RMSF) which at the time was prevalent in southeast Virginia. Since he was dark-skinned, the initial rash was not easily detected, and the diagnosis was not considered. Having seen dozens of cases of RMSF in Chapel Hill this case looked pretty straightforward to me.

I immediately started chloramphenicol and steroids. Within 48 hours, Mr. Wright had awakened and defervesced. His kidney function returned several weeks later at the same time that convalescent titers confirmed RMSF. This is, in our trade, referred to as a *resurrection consult*. I then remembered what one of my colleagues who was already in private practice had told me rather prophetically, “They won't know what to do with you until they see your first resurrection.” His words were true. After this case, the housestaff began referring critically ill patients to me. The ICU had become my second home.

Infectious disease differs from most other medical specialties since it claims no organ system. This requires a firm broad knowledge of internal medicine. In order to work closely with other internists and medical specialists, you must demonstrate that you can talk their talk.

Communicating knowledge and ability are among the best ways to demonstrate your competence to potential referring physicians.

But in a non-academic community the consultant must walk a fine line. On the one hand his work must show that he can deal effectively with a variety of medical situations, but on the other hand his actions and words must not serve to embarrass the referring physician. I cannot emphasize this point enough. In procedure-oriented specialties such as gastroenterology, cardiology, or pulmonary, this is not as much of a problem since the referring physician doesn't practice these invasive skills and is not potentially intimidated by the consultant. In the more cognitive specialties such as ID this *can* be a problem.

It's understood that most physicians can order antibiotics. When the ID specialist comes up with the correct drug – such as the chloramphenicol in the previous case – the referring physician may feel threatened especially if the specialist changed or modified the original diagnosis. This will be discussed in more detail in the chapter on affability, but suffice it to say that *humility* is an important catchword. Physicians tend to judge each other by using themselves as the benchmark.

It is important to demonstrate your ability but do not gloat over it. And certainly do not denigrate your referral source.

I had this vital point brought home to me by an older and well-respected internist in town, Dr. Stern, about a year after I had arrived. I had decided to get consulting privileges at a smaller hospital and needed a letter of recommendation. I asked Dr. Stern for this letter since he had referred many cases to me and had the opportunity to observe my work. A week later I received a copy of the letter of recommendation he had sent to the hospital

administrator on my behalf. Mostly, he supported my application, but he had included this sentence: “Dr. Green is a competent specialist who is a bit arrogant at times and should be watched carefully.” *That* statement was the kiss of death for me. Here was a physician for whom I had great respect who had recommended me with a major misgiving. Obviously, my self-perception and the community’s perception of me were quite different as far as Dr. Stern was concerned.

After receiving this letter, I waited a day or two before confronting Dr. Stern. “How could you say something like this in writing when you knew it would hurt me professionally?”

He replied, “I wrote two letters. The one to the hospital did not contain that sentence. The other letter was meant for you.” I was embarrassed to ask if many physicians felt the same way about me. I was also angry since I believed I had been doing a good job. It wasn't necessary for Dr. Stern to discuss my persona or even cite examples. He had just done me a big favor by issuing this wake up call.

“Tone it down. Be a bit more humble. You are not God's gift to this community.”

Dr. Stern has since passed away, and I was honored to give one of his eulogies. I spoke about his *rachmanis* which is a Yiddish word loosely translated as *compassion*. He had personally demonstrated *rachmanis* and humility by making home visits to dying AIDS patients. Unfortunately, it has taken me many years to fully adopt this important trait.

As I mentioned in the preface, it is essential to get reality checks such as this now and then. I do not suggest mailing out questionnaires or conducting

telephone polls. These are expensive and of dubious value. I do, however, recommend discussing your community-perception with trusted colleagues, nurses, and your office staff. These people should tell you the truth. *But be prepared to change your behavior if their feedback suggests you may be offensive.*

I have a colleague who came to our community from the faculty of a prestigious East Coast medical school. I consider him to be a brilliant diagnostician whose consults are always educational and informative. He had a rough time acquiring consults but not for reasons of arrogance. Quite the opposite. It appeared to others that he really did not care about the patient, the problem, *or* the referring physician. His attitude appeared blasé which may have reduced his stress level but did not improve his business. In a university setting with a ready source of consults this might be tolerated but not in the world of community medicine. The television character of Marcus Welby, M.D., for example, was perceived as successful solely because he projected a caring attitude. Again, the chapter on affability will deal more with this issue.

Maintain your ability and knowledge base.

The demands of a busy practice and family life often leave little room for continuing education. We all have our own ways of satisfying this requirement such as formal lectures, audio or videotapes, journals, structured courses, Internet sites, etc. For many physicians it may be a combination of learning opportunities. Whatever you do, think of continuing education as physical exercise for your mind. It is most effective when you exercise it on a regular basis using a regular

routine.

How many times have you seen your journals pile up until your spouse reminds you to throw them out? Then you feel guilty about getting rid of these journals that you will probably never read anyhow. From my own experience – and I subscribe to eight journals – less than 10% of what is published is of any real use to me. Yet I used to feel guilty about not reading all the articles.

While I was in my training, familiarity with current journal articles was regarded as a high form of roundsmanship. Being able to quote the current literature made you appear to be a better doctor. However, unless you are a speed reader, studying every article is extremely time consuming, and the knowledge gained is often not worth the effort.

There are some articles that should be read thoroughly, some skimmed, and most avoided. I decide what to study by first reading the last sentence of the abstract which is really the conclusion and entire premise of the article. I think of this as “first having dessert.” If the dessert looks good, then read the abstract. If that seems relevant to your practice, go for the entire article. There may be other very interesting articles which you certainly may read for enjoyment, but if you really want to improve your knowledge base and effectiveness as a consultant, the article of your attention must answer the question, “Is this information relevant to my practice?” If the answer is, “No,” then move on. Do not feel guilty. You are on an important mission and need to focus on the goal of self-education. If you like the article, tear it out and put it into folders with clearly defined topics you can return to later. Computer files would be more sophisticated, but the

effort to log in the articles might not be an efficient use of your time. You could just get a filing cabinet. From time to time, discard outdated or disproved material. There is much pleasure in throwing out junk, and it can provide a valuable review.

Lectures are often boring. Most community hospitals have Grand Rounds which award CME credits. In fact, this is the way most physicians get their CME's. Since no test is given, there is no way of knowing how much information has been absorbed. Being at the lecture and signing in are the only requirements for the CME's. In many cases the lecture is essentially an infomercial sponsored by a pharmaceutical company. The visiting professor, if paid by the drug company, is often expected to focus on the virtues of their particular drug or technique. A major problem with Grand Rounds is that the topic may not be suited to the general audience. A psychiatrist might be less concerned about the latest drugs or techniques for weaning a patient from a mechanical ventilator. By the same token a pathologist may not be highly motivated to know how to prescribe antidepressants. And yet everyone shows up for Grand Rounds since this is the easiest way to get CME's and have breakfast or lunch at the same time. My advice is to attend lectures that you feel are relevant and avoid the rest. Your time could be spent better by scanning journals in the library.

If you need more CME's, take approved courses either in person or self-study. For me the Medical Knowledge Self-Assessment Program (MKSAP) sponsored by the American College of Physicians awards 146 Category I CME credits. This satisfies my state board requirement and qualifies me to receive the AMA Certificate of

Recognition which also looks very nice on my wall. This course is much less expensive than taking off several days of practice to attend a lecture series in another city, and I can move along at my own pace. The MKSAP is great for the general internist and consultant since there are special courses designed also for most medical subspecialties. The MKSAP is my most valuable resource for maintaining my abilities as an internist and an ID specialist.

Courses are a good source of CME's if they are given in conjunction with a national medical convention. Here you can kill two birds with one stone. You can choose a course or a group of lectures of interest while at the same time enjoying the company of colleagues and friends and having a pleasant time in a big city. Again, choose your lectures carefully. If the biochemistry of gonococcal ribosomes is not relevant to your practice, avoid the lecture unless the lecturer is a terrific speaker or you are curious about the topic. *Your time is precious, and your mission is to gain knowledge as efficiently as possible.*

For consultants who travel to several hospitals, audiotapes may be helpful. Driving is usually down time, but you can make it productive by listening to tapes some of which actually award CME's. You may have to take a little quiz to prove you have learned something, but that just forces you to pay attention.

I recently took a 12-hour video CME course on bioterrorism sponsored by United States Army Medical Research Institute of Infectious Diseases (USAMRIID). It was excellent, and the workbook tied the information together. I did have to take a test at the end, but the training materials were so clear and easy to understand that the quiz was no

problem. I have found the armed forces method of educating and training medical professionals to be very effective. They decide which facts are most important and repeatedly emphasize this information throughout their presentation. Constant drilling gets their point home.

Another way to master a subject is to give a lecture or write a paper. Although either approach can be time consuming, it is one of the best ways to develop mastery. I have many prepared lectures that can be readily updated. The use of computer programs to create professional appearing presentations makes this process much easier and more enjoyable. However, considerable time and energy must go into this kind of preparatory work. The added benefit of a lecture or paper is that it is an acceptable form of publicizing your knowledge and skills to the community. One word of caution: publishing an article as a community-based specialist is different from publishing as an academic specialist. The latter must publish to survive; the former does not.

Several years ago I wrote an article on toxic shock syndrome that was published in *American Journal of Medicine*. The hospital librarian made a copy of it and put it on the bulletin board in the Doctors' Lounge. A couple of days later someone had written on the article, "Way to go, big shot!" I still continue to publish articles, but I do not publicly brag about these efforts. Humility remains an important character trait for the effective consultant.

Perhaps the greatest resource for self-education is the Internet. Topics and articles can be pulled together relatively easily from the many websites provided for this purpose. I have

used the Internet for literature searches when writing articles and it has been an incredible time saver. Most major journals are on-line which makes it fairly easy to retrieve important articles. However, the Net can be addictive, and unless you have the time for entertainment or relaxation, I would recommend setting a goal and a time limit when logging on for purposes of self-education.

KEY POINTS IN CHAPTER ONE

Maintaining your professional ability can be a significant challenge for those consultants practicing in a non-academic medical community. Medicine is a lifelong educational experience and hopefully in our training we have learned how to learn. This chapter has described ways to accomplish this goal while allowing time to balance your professional and private lives. To your colleagues you want to appear knowledgeable *but not arrogant*.

POINT ONE

Demonstrate your expertise through consults and advice to colleagues, but avoid presenting an attitude of arrogance or condescension.

POINT TWO

It takes time to develop a professional reputation. A *resurrection consult* can be helpful.

POINT THREE

Never denigrate a referral source or any colleague.

POINT FOUR

Enthusiasm and humility can be complementary attributes as you build your reputation as a trusted and valuable consultant.

POINT FIVE

Try to set and achieve practical goals in your self-education. Do not waste your time reading articles or attending lectures that are irrelevant to your practice.

POINT SIX

Set aside study time sessions several times a week. Exercising your mind as with exercising your body is most effective when practiced regularly as part of your routine.

POINT SEVEN

When you read those journals to which you subscribe, tear out and file the valuable articles, and discard the rest. It not only feels good to do this, but you will also avoid cluttering up your office at home with magazines you will never read.

POINT EIGHT

Master your subject by writing a paper or giving a lecture.

POINT NINE

Get feedback on how you present yourself from trusted colleagues and employees, *then make changes.*

POINT TEN

Be compassionate.