account for amenities. The same issue pertains to gauging productivity. The recently enacted Patient Protection and Affordable Care Act reduces growth in Medicare reimbursement on the grounds that hospitals should be able to achieve productivity gains similar to those in the rest of the economy as a whole. But if amenities are important — and aren’t included in performance assessments — then the productivity of hospitals that offer greater amenities is being understated. Hospitals that are focused on this part of the patient experience may therefore suffer under the new law.

At present, our health care system seems conflicted about the patient experience. Under health care reform, Medicare will begin paying hospitals on the basis of value. Some experts have contemplated using data from the HCAHPS survey to inform a value-based payment system. This survey may tap into patients’ assessments of the nonclinical experience, particularly with its questions about overall hospital ratings and willingness to recommend a given hospital.

On the other hand, process measures of quality have also been proposed. Their inclusion could persuade hospitals to shift their focus from amenities toward clinical quality. Such a shift seems more in keeping with the overall spirit of the HCAHPS survey, whose designers explicitly ruled out including amenity-focused questions, believing that only clinical aspects of the patient experience matter and citing patients saying, “I know this isn’t a hotel.”

We doubt that everyone feels that way, however, and the behavior of many hospitals suggests that they doubt it, too. As health care reform moves forward, we need to decide whether amenities are a valuable part of the hospital experience. If they are, we must account for them in the ways that we measure overall quality, prices, and productivity.

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**BECOMING A PHYSICIAN**

**Gratitude, Memories, and Meaning in Medicine**

Hasan Bazari, M.D.

The card, with its picture of a bouquet of flowers, was on my desk when I arrived at the hospital on Monday morning. I opened it, assuming it was a thank-you note from an interviewee for our residency program. But the handwriting was that of an elderly person who had taken the pains to write, with slants and slopes necessitated by decreased mobility. Under the printed lines, “A little ray to brighten your day. Thinking of you,” the sender had written, “My mother, Mary Louise Kelly, ’83–’84, would be pleased with your role at MGH. Please remember to wear a coat in this cold weather. Respectfully, Ella Kelly Fletcher.” Stuck inside was a pink Post-it note that read, “Hasan, I am a patient at the MGH. I will be admitted 02/04/2010 to the Orthopedics Service for a left shoulder replacement. We have always truly appreciated your care and concern for her. May God continue to bless your work.”

Not immediately recollecting Ms. Fletcher, I set the card aside to attack my daily deluge of e-mails. Mondays are always a whirl of conferences, challenging patient interactions, and administrative meetings. I soon received a call from the family of a patient with severe cardiomyopathy, end-stage renal disease, and a renal-cell carcinoma, who had had cognitive decline after starting hemodialysis; his family wanted him transferred from the rehab facility back to the hospital to sort out end-of-life issues and withdrawal of dialysis. My day passed quickly.

The next morning, the card still lay on my desk, and a faint memory started to gather in my mind; 1983 was the year I started as an intern. It dawned on me...
that Mary Kelly was the very first patient I had admitted to the hospital — the first patient whose room I had walked into and to whom I had introduced myself as a doctor. It was June 26, and I was still in shock that I had matched at Massachusetts General Hospital, still waiting to be discovered unworthy of my post.

That first admitting day was one of high anxiety — with everything so new, I was awkward and painfully aware of my lack of experience. Having participated in the training of young physicians for the past 16 years, I now know that such feelings of inadequacy are common, if rarely expressed. My first admission came around noon, when I was called to accept a transfer from the surgical service. I went to the surgical floor and reviewed the chart: the patient had been admitted with bleeding a month earlier and was found to have gastric cancer. After it was resected, she had been given chemotherapy. She was neutropenic, jaundiced, and febrile. It took me several hours to get her admitted, and I spent anordinate amount of time writing a detailed, seven-page note — an indulgence I would later come to regret as the night went on and time seemed to run out. I then became her primary care doctor and cared for her for the next year, until she died of metastatic disease. That first night ended with three admissions, only two of which I managed to write up, but despite my initial anxiety, I went on to enjoy my internship and training. Today, navigating one’s emotions during the development of a professional identity is one of my central concerns as the director of a training program. The roles of fatigue, long work hours, and loss of empathy during medical training are intertwined, and we have long failed to acknowledge the detrimental effects of the traditional approach to training physicians.

As I read and reread the card, I was amazed that the daughter had remembered the events of 26 years ago. Despite my clumsy attempts at being a doctor, I seemed to have had more of an impact than I imagined. Time has erased many of the details of Ms. Kelly’s case from my memory, but clearly it had not done the same for her family.

As the week went on, I felt more and more touched by the card. It brought to mind what I often tell internship applicants on interview days: the future of medicine is in safe hands not because of what happens among policymakers in Washington, but thanks to the dreams and aspirations of the next generation of physicians. Their compassion and dedication are the engine that has driven the care of inpatients for decades, even as trainees struggle with uncertainty and slowly acquire experience. The rigors of training can challenge the idealism and compassion that most aspiring physicians bring to their chosen field. The high rate of burnout during residency reflects a failure to modulate the intensity of the experience from the trainee’s front-row seat at the drama of life, illness, suffering, and death. Whether physicians’ emotional development is optimally supported during training remains a question that should drive efforts to improve our programs.

I met Helia Kelly Fletcher the day after her surgery, as she worked with a physical therapist to ameliorate the effects of severe arthritis in both shoulders. She again expressed gratitude for my care of her mother. “We were able to keep her home for so long because we knew that if we ever had a question, we could call you day or night and you were always there,” said Ms. Fletcher. “She always worried that you dressed too lightly for the cold weather in Boston. She always asked you to wear a coat. What we remember is her last hospitalization, when she was dying and you visited and sat with her while we went to lunch. We did not want her to be alone those last days of her life. We often talk about you,” she went on, “but this was the first time we looked up what you were doing. Thank you for all that you gave us.”

It hit me once again that sometimes simply being silently present with a patient may be the most meaningful kind of care. I hugged this now-elderly daughter of my one-time patient, reassured that my career had meaning.

Even in this era of health care as a business, with increasing pressure to contain costs, the secret of being a good doctor clearly still lies in what we do, feel, and communicate at the bedside. To ensure that the next generation of physicians is equipped to give patients what they need, we must nurture their humanism and empathy — and redouble our efforts to preserve physicians’ ability to truly care for patients and their families as they bear witness to the inevitable cycle of birth, life, illness, and death.

The next day, I met with the wife, daughter, resident, palliative care doctor, nurse, and case manager of my current patient with renal failure, cardiomyopathy, and renal-cell carcinoma. The patient
was alternately confused and lucid. We talked about whether dialysis should be continued. The family did not want to prolong the patient's life but was afraid of discussing it with him; we decided that the medical team would do so instead. But when the resident and I met with the patient, he surprised us: he and his wife had already discussed the matter, he said, and he wanted to discontinue dialysis. We sat with him and told him that we would continue our efforts to minimize his pain and suffering.

As I left for the weekend, I stopped in and told my patient that it had been a privilege caring for him. "It has been a privilege being your patient, doctor," he replied.