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White Coats

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I HAVE BEEN THINKING about doctors' white coats since I started working at Butler Hospital, where the doctors don't wear them. Later I learned that doctors' white coats in Europe are short-sleeved, in contrast to ours. I was told that short sleeves, in both coats and shirts, reduce infection trans-



mission. It turns out that there are a number of publications evaluating the risks associated with white coats, as well as men's neckties spreading infection. (I didn't find any that compared white coats to street clothes, but assume that most doctors change their street clothes more frequently than their coats, the main cause for infection spread, making that study moot.) It appears that there are no clear-cut data indicating that American doctors are spreading infections more than our European colleagues. There are data, however, that washing the coat less than once a week is definitively associated with infection spread and I am certain that almost every house officer I've worked with over the past several years washes the coat far less, if ever.

There are also many studies on patient and doctor preferences for whether the doctors should wear a white coat at all, whether neckties or other formal attire are more or less desirable, and how scrubs are perceived, compared to white

coats or street clothes. The results vary with the medical discipline and the country. In general, patients like their doctors to be well turned out, with some preferring white coats and some not. All patients, when informed about infection risks, chose the clothing that minimizes that risk.

The white coat is highly symbolic, which is why we still wear it. I assume that it was originally used to convey cleanliness, and, being bleachable, was easier to clean than other colors and revealed its cleanliness. That seems to have become less of an issue in the U.S. It now conveys professional standing, and dedication, as evidenced by the "white coat ceremony." I trained at an Ivy League medical school that regarded tradition with extreme reverence. Medical students wore short coats that ended at the thigh and fellows and attendings wore long coats that went below the knees. I am unsure if the authorities in charge then were more chagrined by ignorance and bad judgment than by sloppy or dirty attire and comportment. In that distant day there was no air conditioning and the larger wards had 16 beds. While summers in New York City weren't as hot then as they've become, they were, nevertheless, often very hot and humid. Medical students and doctors were expected to wear their

white coats, and men had to wear neckties, no matter what the temperature or humidity. It was forbidden to eat or drink in front of a patient. All patients, excepting children, were called by Mr., Mrs. or Miss; the word, Ms., not yet having been invented. A social gap was intended and enforced. This was considered the "proper" approach to medical care. The white coat was an important part of that divide.

I absorbed this social construct and continue to follow the guidelines. I rarely use first names, and limit this to a few patients I've known for many years or to the occasional teenager I see. I routinely violate HIPAA regulations by calling patients into my office from the waiting room by their surname. These rules entered my DNA long ago.

I work at Butler Hospital, a psychiatric hospital where I am one of only two doctors, the other also a neurologist, who wear a white coat at work. I wear mine every day, all day. Neither the attending level psychiatrists nor the house staff wear white coats. Without any data to offer in support, I nevertheless have viewed this as a mistake. Appearance is important, and, I believe, the white coat lends an air of professionalism that is helpful in treatment. I have often thought about suggesting a simple study to assess my theory, but have not got past the thinking phase.

Psychiatry is no less a medical discipline than surgery, yet it *is* perceived as being quite different. It is considered

less scientific, more grounded in social approaches rather than clear-cut “medical” treatments. It is often considered a less prestigious field than many of the other medical specialties, and, I believe, the choice of not wearing a white coat reinforces the belief that it does have a reduced status. I have not seen any other specialty routinely eschew this symbol of our profession. The “white coat ceremony” symbolizes the importance of this.

I am certain that there are strong reasons that psychiatrists do not wear their white coats and that the choice reflects an attempt to foster a closer therapeutic alliance. Nevertheless, I suspect that this is a mistake. A simple experiment would answer that question. ❖

Reference

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OPINION

The FY18 proposed state budget released by Gov. Gina Raimondo on January 19, 2017 includes elimination of upper payment limit payments (federal funds used to ensure Medicaid reimburses hospitals at an amount equal to Medicaid), Medicaid payment reductions, and cuts to inpatient mental health providers. The Hospital Association of Rhode Island continues to analyze the impact of these proposals.

HARI Reacts to Governor’s Proposed Budget

The Hospital Association of Rhode Island and its members are disappointed the proposed budget includes hospital payment cuts. We will continue to work with the General Assembly and Administration to find lasting solutions that address state fiscal problems while ensuring a financially stable healthcare system.

Hospitals provide nearly \$7 billion in economic impact to our state. Elected officials must recognize hospitals are critical to a strong, healthy and stable Rhode Island. We urge them to make the appropriate investments to ensure the safety net is protected for Rhode Island patients.

As officials in Washington, D.C. consider the repeal of the Affordable Care Act, nearly ten percent of our state faces future problems accessing healthcare. In addition, hospitals could struggle with \$1.7 billion in cuts on top of the \$1 billion in reductions used to fund implementation of the Affordable Care Act.

We urge Governor Raimondo and the General Assembly to protect access to healthcare during this time of uncertainty.

— Michael R. Souza
President, Hospital Association of Rhode Island

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Complexities to Consider When Patients Choose VSED (voluntarily stopping eating and drinking)

HERBERT RAKATANSKY, MD

PATIENTS WHO DEVELOP progressive fatal diseases such as untreatable cancer or progressive dementia have few options if they decide, that at a predetermined point in their disease, they prefer to die.

Physician assisted suicide (PAS); now legal in 6 states (OR, WA, VT, CA, MT, CO) is not an option

in RI. Currently 4 states (NV, NC, UT, WY) do not address the issue. The right of patients to refuse medical treatment, however, even if life saving, has been affirmed by the Supreme Court (based on the 14th amendment) and is accepted by the medical profession.

These patients, facing a terminal illness and preferring death to the perceived mental and physical distress, may elect to stop eating and drinking (voluntary stopping eating and drinking or VSED). Persons who elect that approach will die in 7–14 days. In contrast to PAS, VSED requires no action by the doctor and requires no physical action by the patient.

VSED in a non-terminally ill person might be considered suicide. Some presumably competent and capacitated persons, however, cease oral intake of food and sometime fluids, to protest political or other social policies. Our government recognizes the right of persons to engage in these behaviors even if they lead to death, though it has acted in contrary



ways on occasion (ex., Guantanamo). It is established ethics policy that doctors should not force-feed competent, capacitated persons who elect to stop eating and drinking. Insertion of per-oral tubes or IV lines without consent is unethical and illegal.

Interestingly, the Israeli government does not allow prisoners to die as a result of self-starvation. These acts are regarded as “suicide terrorist attacks” and treated as such. The ethics guidelines of the Israeli Medical Association, like The World Medical Association and the AMA, prohibit doctors from participating in forced feedings, putting Israeli physicians in a difficult position. Capital punishment is a similar situation. Ethics standards forbid doctors’ participation in any manner. Whether capital punishment is wise and worthwhile is for society to decide and then to carry out, if it wishes, but without any assistance whatsoever from the medical profession. If a government decides that force-feeding is wise and worthwhile then it, too, should be accomplished without any assistance from the medical profession.

Getting back to competent, capacitated persons with terminal or disabling, diseases, who elect VSED – should doctors intervene? Forcibly giving nutrition and fluids via enteral or parenteral

means would be a serious violation of our obligations to act always in the best interests of our patients – as they determine them, and a violation of patient autonomy. Placement of an NG tube or an IV line is a medical procedure requiring consent, which, of course, would never be granted.

But doctors could treat the mild discomfort associated with VSED. Thirst and hunger reportedly are not severe after the first day. And these patients have other terminal diseases for which they need appropriate supportive care. However, doctors and other caregivers may have personal values that conflict with VSED and they should not be required to participate.

Consider the case of a Canadian woman with a valid advance directive to withhold food and liquid if she developed advanced dementia. The institution where she was being treated felt that food and water were not medical issues and, additionally, that the patient had changed her mind. A judge decided that, indeed, she had changed her mind because she swallowed when spoon-fed, even though she had advanced dementia and was non-verbal.

If eating is a personal, not a medical, issue what is the responsibility of the institution? Might an institution find itself morally and emotionally uncomfortable with VSED? Could the institution be considered to be complicit in a suicide?

Institutions should have established

policies that address these issues and include but are not limited to supportive and educational measures for the staff and family, safeguards for the patient (psychiatric consultation, etc.) and ethics committee consultation when requested.

VSED, thus, is an option for competent, capacitated persons with terminal disease to avoid pain and suffering. It may be morally more acceptable to some than PAS and, legally and ethically, VSED has been accepted in other situations. Also VSED requires no physical action by the patient (in contrast to PAS), and no order, prescription or action by a doctor.

What about a patient who has lost the capacity to make medical decisions and has left instructions to cease oral food and water at a specified point in a terminal disease? Can a proxy carry out (or negate) those instructions?

First we must ask whether oral feeding is medical care or personal care. Medicare considers assistance with eating as personal care and will not pay for

it. If oral feeding is personal care rather than medical care, the proxy designated to authorize medical care may not have the authority to order VSED (in spite of specific directions in the durable power of attorney). Additionally, state law may limit the health care surrogate's authority (thus defining VSED as medical care). In WI, NH, MO and NY, health care surrogates cannot discontinue oral nutrition.

Since it does not seem to be clear in RI whether oral feeding is personal or medical care, both medical and general legal powers of attorney may be needed to authorize a proxy to implement a patient's directive to initiate VSED. However, we do not know what courts might decide in these cases.

RI law defining the authority of a health care surrogate to intervene regarding nutrition does not mention voluntary eating and drinking in its list of medical interventions. The RI "medical orders for life-sustaining treatment" (MOLST) form does not contain a specific decision-making question about

oral feeding but does state:

"Offer food by mouth if feasible and desired" (obviously not desired if the patient has elected VSED). The RI MOLST form thus is ambiguous about whether oral feeding is medical care though it appears to offer the patient the opportunity to elect VSED.

These vexatious issues would best be addressed by a community discussion, with the aim of arriving at a consensus policy for our state. Until then, the multiple moral and legal complexities suggest that doctors advise patients, like the ones mentioned, who are considering VSED to consult an attorney versed in health care law. And institutions, in order to treat these patients appropriately, should formulate and have policies about VSED in place. ❖

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