

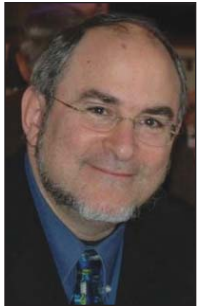
Primum non nocere

A Commentary

100 Precepts for My House Staff

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Sometimes we try to distill long experience into words, whether aphorisms or full paragraphs. Rilke's wonderful prose poem expresses this very well in the part that begins, "For the sake of a single verse, one must see many cities, men and things. . . ." ¹ While medicine has only some features in common with

poetry, what reverberates is the wish to impart an affecting draught of beauty or wisdom or insight, in the case of poetry, after many years and decades of immersion in life; and I here offer some fruits of long observation and participation "hip deep" in clinical care and in the teaching of residents.

I have taught pathology and physical diagnosis and now internal medicine and geriatrics for decades. It's time to write down some principles that I hold most dear. The purpose is to articulate insights and behaviors that are useful to the learner, and that I consider important for any practicing clinician to know and to perform. I hope to hand out this listing when I orient new house staff on my unit, to supplement rather than replace personal contact, for I count on a

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role with further decades' physicians-in-training and nurse practitioners-in-training.

Why share the precepts with the readers of CONSULTANT, most of whom are not residents or trainees? Simply in the hope that even if just a few of these represent helpful formulations, they provide a service. Of course I hope that persons of kindred outlook, often self-described as "old-time clinicians," will find resonance and support in the philosophy and values expressed. Some readers may find the tone preachy, judgmental, or self-righteous. I hope not. To say "I know the difference between right and wrong" is not the same as saying "I think I'm better than others." These precepts do take a stand, and they represent core values. Our values and morals evolve continuous-

ly. So do the means by which we put them into action. Many clinicians contribute to medical education. If other teachers can employ some of these ideas, that will fulfill my intent.

Some comments and practices will doubtless strike the reader as simple, local, and particular. That too is the humble and genuine nature of the places we work and the people we are and those we look after. The physician-poet William Carlos Williams said, "No ideas but in things," referring to something akin to this²; William of Ockham, a medieval philosopher whose ideas permeate Umberto Eco's novel *The Name of the Rose*, formulated a similar notion.^{3,4} I trust that any reader will freely adopt any item by changing "Tuesday" to "Monday," or whatever else is needed. [Any reader is welcome to download the text from the CONSULTANT Web site, www.ConsultantLive.com, and modulate it for best fit with her or his practice and teaching situation.]

These 100 do not drain the cup of my clinical maxims. But it seemed that if one went on too long, one would sacrifice any pleasure that a reader might take in them. And if that meant they were not put to use—at a minimum as the subject of vigorous debate—I would have just filled up printed pages rather than making a contribution, however infinitesimal, to the bedside care of patients. Heaven forbid: we are all far too busy to indulge in such an exercise.

1 This is a unique opportunity. You will get a great deal out of it *only* if you put in commensurately. This unit is challenging, educational, and extremely important to me and to the others who work on it. Regard your time on it as a privilege. Maintain our high standards. Take pride and grow as a physician. These are among the toughest of patients; pediatric cancer patients, profoundly developmentally disabled persons, and those with advanced HIV disease come to mind as comparably challenging. Gain skills that will export well to the rest of your career: jump in with both feet.

2 Two of the many things you can expect to get out of this are to lose the fear of psychiatric patients, and the subliminal dislike of them that can trail in the wake of fear; and to gain skill in looking after the special needs of demented persons.

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3 I expect you to arrive early in the morning, by 8 AM or better at 7:30 AM; see patients before I do. Take report first thing from the charge nurse. Be helpful. Know that everything you do or don't do is important.

4 Be accountable. Know that I will write a detailed, careful, and rigorous review of your work which can be useful and sustaining, or otherwise. Your constituencies are the patients; their families; all staff; the clinicians who will resume care of the patient after he or she leaves our unit; and me; and yourself.

5 Open the chart electronically. Always read the admitting history and physical examination. Read the other MD notes, including the MD co-signature notes. Read the psychiatric admission note. Read all the orders. Read the nursing daytime notes. Read the daily psychiatrist notes. Use "care trends" to review the BPs, the pulse rates, and the fingerstick glucose measurements using "cardiovascular" and "nutrition," respectively. Watch the weight for trend. Watch the temperature. Watch the I&O if appropriate.

6 I will round each morning at or before 9 AM. If you have class in the morning, come in beforehand (!) if need be, and as soon afterward as possible. On such days if I miss you in the AM, I will re-round, duties permitting, at 2 PM.

7 Be prepared. Don't tell me that you did not see the patient. Don't tell me you ausculted through clothing. Don't tell me you palpated the abdomen with the patient in the wheelchair. Don't embarrass yourself.

8 Don't bluff.

9 Don't be embarrassed to say, "I don't know." These are the most underused words in the physician's vocabulary. Better still if you can follow up with, "But I will find out."

10 You can never harm a patient by admitting ignorance, whereas you can do harm by pretending to possess information that you do not. Likewise by agreeing that a finding is there because I say it is: I too am fallible. Don't be a yes-man to the emperor's new clothes.

11 I have a great deal of other duty. Consider me unavailable except 9-10:30 AM and 2-2:30 PM. If I am not available, either determine that the issue can safely,

painlessly await our next rounds, or get another attending to oversee you. Talk to the Fellow to determine when to make an exception. The other attending will also be very busy.

12 You are my personal ambassador. Act accordingly.

13 Wear a clean white coat. Dress like a leader because when you come on the unit, that is how you will be viewed regardless of how young you are, how low on the organizational chart.

14 Behave and speak like a leader: calm, polite, composed, poised. A foreign accent is no barrier to this. Skillful physicians come from everywhere. Careless speech undermines efficacy.

15 You don't have to know everything to lead well (see #9, above).

16 I dare you to try to gain on me as a physician. The only way is to work harder (or better) than me, and I work hard.

17 My goal in working with you is not to steer you to a career as a geriatrician, rather to help you become better at whatever track you are following: internist, nurse practitioner, family practitioner, or for the few who so choose, geriatrician.

18 There is an infinity of lessons you can export and generalize to whatever patients you see in future, and in particular to other difficult patients such as the frail elderly.

19 Go see the patient. Sit down to interview—don't loom over the patient. Get your hands dirty. Clean them afterwards. Be a hands-on doctor. Do follow-up and serial physical examinations. You don't have to auscult the lungs each time if the issue is not cardiorespiratory. If you are doing a rectal, position the patient carefully and tell him or her before you touch and again before you enter.

20 At the end of any rectal examination, wipe the patient's backside with clean tissues and tell him or her you have done so. You will diminish misery and humiliation more than you can know: the patient can pull back up the underclothing without soiling it and the hands.

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21 Find the ophthalmoscope, gloves, lubricant, Hemocult, BP cuff, and tongue blades in the clean utility room. Carry a penlight, reflex hammer, gloves, lubricant, pen, paper, a few alcohol wipes, two 2 × 2 gauzes, and 4 nonsterile tongue blades in the white coat you wear whenever you set foot on the unit: don't waste time backtracking to collect a supply that you'll need in the course of the week. Bring a clipboard or a PDA (personal digital assistant). Don't make notes on scraps; that ensures loss. Above and beyond: carry a bandage scissors and spend less time removing Kling gauze; keep the scissors clean.

22 Look at wounds and be sure the nurse joins you for this, since she or he has to see it anyway, and in hearing and responding to what you recommend, the nurse may well offer observations and recommendations of utmost value that had not occurred to you; all will gain from the interaction. Describe even if you can't name.

23 Don't examine patients, not even the external eye, in the dining room. Use the Mom rule: "If it was my Mom, how would I like her examined in public?"

24 Learn to apply and remove the brakes on a wheelchair.

25 Learn how to help lift a patient (by the waistband, not the arm: don't cause shoulder separations and rotator cuff tears in susceptible old people).

26 Learn how to turn chair and bed alarms on and off. Always leave them *on* when you are finished. Don't leave a mess. Maid service was abolished on this unit 3 years ago.

27 Learn to go into the dining room and bring out a patient. Greet as many patients as you can by name.

28 Set limits: don't spend 20 minutes trying to explain something to a demented person. Don't attend only to those who noisily seek you.

29 Don't believe the patient or the family who tells you that you are the only one who understands or who cares; these comments mean something very different from their overt content. If you don't reject them, you'll have much more emotional difficulty in rejecting the equally untrue assertions by those who call you the worst alcoholic doctor on earth, incompetent, too young, etc.

30 When you tell me a case, don't replicate your writeup; I will read it. Tell me instead what you have found and what you'd like me to go over at bedside.

31 Know that I will ask you, "What did you learn?" with great frequency after we have seen a patient, and will expect you to have thought about this and to tell me something added to your bedside toolbox. Avoid dodging via a compliment to me. Don't duck by pretending you learned the same thing that the trainee just before you uttered. Don't be afraid: nobody will make fun of an odd answer; this is a very safe place to speak your thoughts bluntly.

32 The nursing staff, including the CNAs (certified nursing assistants), unit clerks, social workers, rehabilitation staff, and recreation therapist will work very hard to help you.

33 Learn their names. Address them by name and always state your name.

34 They are not your servants: be mindful of this. When they help you, it is a gift and needs acknowledgment. They often talk to me about how you treat them and how well you are doing, not to tattle but as colleagues who share the work of nurturing your professional growth.

35 Don't sit anyplace reading the newspaper: even if you have a forced delay, it gives the message that you are letting others carry all the weight.

36 Carry a medical article in your clipboard and read it during a forced wait. Tell the nurse what it was about and how you will apply the information to help one of your shared patients.

37 That night at home, replace it with a fresh unread article.

38 If you run out of unread medical articles, ask why you are in this profession.

39 Don't interrupt a nurse who is working, to ask her a question or to ask him for assistance every 15 minutes: they have much too much work of their own to baby-sit you. Batch your requests; expect the same courtesy applied to you. Think how you feel when you are interrupted every 5 minutes. I can be rock-sure that you have experienced such interruptions.

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40 Don't leave coffee cups. Don't hog the computer. Don't cut in if another member of the team is on the computer.

41 Don't go on the Internet on a hospital computer unless it is to PubMed or Up-To-Date to answer an immediate question about a patient you are treating at that moment.

42 Don't bring in your cell phone, or if you must, don't turn it on.

43 Do feel free to ask, politely, if the nurse can come look at something with you if it is difficult; or to ask the nurse or CNA to help you get a patient into or out of bed or into or out of clothing for examination.

44 If family is present, use it as an opportunity to enhance your understanding of the case and to update them. Don't regard family as an enemy. Don't lose patience because they have a lot of questions: it is just one patient for you, but the calamity of a lifetime for them.

45 Tell the family that you are a house officer. We are a teaching institution. This is normal. Good communication does *not* come exclusively from the attending physician. Never apologize for being a resident or a student. These are honorable estates without which attendings would become extinct in one generation. Families who ask that no trainee work with them fail in the social contract of medicine and of the teaching hospital.

46 When patient or family queries you based on 10 minutes' search on the Internet, feel free to say gently, politely, firmly that information without context and without rigorous fact-checking is the bane of the Web. Our decisions reflect years of training and experience that cannot be replicated by doing a Google search.

47 If family is receptive, feel free to say, respectfully, that medical, psychiatric, nursing, rehabilitation and social work professionals bring three special elements to the conversation:

- Technical knowledge.
- Knowledge of parallel cases: even though each person is unique, one has insights from other human beings with similar problems that one has looked after.
- Objectivity: we are sad when our patients ail or die, but our hearts are not being wrenched forever because we are not losing the one and only father we ever had.

Then acknowledge that they also know what we cannot: a lifetime of contact; and profound personal connection, though our patients are precious to us.

48 If a family tries to imply that their money or ethnicity matters to you, think to yourself, even if you don't say it, "I would try to do as good a job for Bill Gates's mother as I would for a homeless man."

49 Teamwork, teamwork, teamwork. Expect to have scheduled family meetings, and ad hoc telephone calls when there is a change of status, along with a social worker and/or a nurse, often with both; sometimes the charge nurse will participate, sometimes the nurse manager. Often I will. When the call is not about a deterioration, start out, "Hello, this is Dr Jones, from Hebrew Health Care, calling for Ms Smith. Is that you? Good, please don't worry, I am just calling to provide you some updates and to gather some more information about your husband." Wait 10 seconds for the panic and tachycardia of the recipient to slow—way too many families are conditioned by experience to believe that a physician on the telephone equals a death or a calamity with ICU transfer. Then, "I am on the speaker phone with Nurse Kelly and with Ms Brown the social worker, so we can all hear you and contribute."

50 Dump the old outdated, hurtful posture that the doctor is the center (or that the internist can answer for the psychiatrist). We are a team. Don't cover everything yourself.

51 Attend treatment planning meetings on Tuesday and Friday at 11:30 AM; you will hear a great deal. Team will be very deferential, to me if you say nothing, and to you when you speak up. Please ask questions, but not of the ilk, "What is the dose of sublingual nitroglycerin?"

52 If the nurse asks me a question in your presence, try to answer it; I will be very happy to be interrupted by you for this purpose. Insist on being a team member, not a visitor. (If you are merely a visitor, you are guaranteed to be unhappy and unproductive.) Don't contribute passively to any staff member's turning to me as the be-all and end-all. I ain't, and it hurts our care.

53 Gaining confidence and competence are equally vital elements in professional growth. If the nurse asks you a question about which you are unsure, give your opinion and acknowledge uncertainty; feel free to ask others for input. Nobody loses face. If I, for instance,

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corroborate your opinion, you gain confidence and credibility. If I disagree, these things are not diminished, you learn something, and we serve the patient jointly.

54 If a patient refuses to talk, or to be examined, be *simple*, be creative, but don't be a bully; a second try at another time is often the best means of getting the information you need without going to war. Pick your battles. Sometimes it is a great idea to decide that the patient should win a battle. Families too, as long as the patient won't be ill-served by acceding to their wish.

55 If others interrupt you every 5 minutes for non-emergency items, please tell them, "I can't get to that right now; please let me complete what I am doing," and when you *have* completed it, make sure to go seek the speaker out and to respond to the query.

56 Teach yourself more about the computer.

57 Check your mailbox in the department of medicine at least twice daily.

58 Check the laboratory fax in the department of medicine at least each morning between 10 and 11, and each day at 2:30 PM by which time all routine results are expected to be in. When you find laboratory reports on behavioral health hospital unit patients, read them, initial in lower right corner, take any action, eg, ordering next warfarin dose and writing a warfarin anticoagulation note. Turn them in to behavioral health hospital unit staff. If you need to discuss them with me but they are not an emergency, make a copy or make yourself a note.

59 Routinely write an "MD/APRN brief note" except for full admission "history and physical." Always write descriptive notes; don't use a lot of the tick-off options in an "h and p." Sequence your write-ups logically. Cover one problem at a time, so the reader won't get confused or overwhelmed. Proofread your write-ups. Fix spelling and grammar errors. Have pity on the reader who may depend entirely on your words.

60 Bill your notes as "Hospital, medium complexity follow-up" unless they are admissions; our attentions to our patients on this unit are always at least that complex. This is a hospital unit, not a skilled nursing unit, so a "nursing facility/nursing home note" billing code will always be erroneous; the people from

health information systems (medical records) will pick this up and ask me about it, based on the cycle of information review, long after you have graduated from the unit, and I will waste time correcting it. This is only a wise choice if you loathe me and wish to strike a blow from outside my immediate reach.

61 Type in diagnoses at the bottom of the bill; don't use the tick-list for diagnoses. List only diagnoses that are justified by your note: just mentioning hyperlipidemia as a preexistent condition does not justify billing it. An easy way to get the diagnoses on the bottom without having to do any extra keyboarding is to name in lettered list format the problems you'll discuss at the start of the assessment piece, then copy-paste to the billing area, then go back and expound. Never put dementia first unless you have seen the patient purely for that problem. Ask me for a demonstration if you don't understand.

62 Write the same note, but bill as a "courtesy visit" and skip putting in diagnoses, when no attending has seen the patient or is going to see the patient with you that day; or when you are writing about a thought/follow-up that has not included seeing the patient; or when you want to talk about a laboratory or an intervention, without having seen/touched the patient that day. In the "physical examination" portion state directly, "Patient not seen today."

63 On any patient on warfarin, on admission and with each follow-up INR, write a warfarin anticoagulation note; learn how to save time with this by using "document spreadsheet." Also write an order for the next INR on the date corresponding to the one you put in the warfarin anticoagulation note. If clinically safe, avoid ordering follow-up INRs on weekends or holidays: the moonlighter then is swamped with other duties and needs one less task.

64 Don't order NSAIDs, including COX-2 selective agents (also known as coxibs).⁵ They equal GI bleeding in our patients, and they can cause lethal hyperkalemia⁶ as well as renal failure.

65 Don't change the psychiatry medicines: the geropsychiatrists do that. How would you feel if they changed our digoxin orders? I like to keep pain medicines as Medicine orders, but sleep medicines can go either way.

66 If I don't give you a paper a day to read or to add to your files, ask for one.

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67 Don't assume that just because another MD diagnosed it or ordered it, it is correct.

68 Don't assume that laboratory and imaging results are always right. They are not.

69 Don't throw away your clinical findings when they conflict with technology.

70 Don't stop *thinking* about what ails your patient.

71 Know that unitary diagnosis, eg, for falls, is less common than multifactorial diagnosis. Remember that *poor safety awareness* is often a major element in falls; this cannot be studied with a Holter monitor nor corrected with a bed alarm. Check pulse and pressure in lying, seated, and standing positions to see if there is an element of orthostatic hypotension in any person who falls; if the pulse fails to rise with a fall in BP, autonomic dysfunction is present.

72 Know that delirium is an acute brain dysfunction whose hallmark is a disorder of attentiveness: either too distractible or hypervigilant. Ask me for a paper.⁷

73 Know what the Mini-Mental State Examination (MMSE) is, the Clock Drawing Test (CDT), the geriatric depression scale (GDS), the FAST scale, and the Global Deterioration Scale.⁸⁻¹⁰

74 Familiarize yourself with all the options on the CODE order drop-down menu and the even fuller list on the advance directive worksheet that I will provide you. Don't fail to include a CODE order on any admission.

75 Whenever we have a CODE discussion with a family, update the computer order *and* write a CODE STATUS note as an intervention. Please allude to the worksheet. Make sure the family leaves the meeting with a photocopy of the completed worksheet in hand (the social workers are very gracious about making such a copy at the conclusion of such a discussion). Counsel the family to photocopy it and to provide any future facility with copies for the director of nursing, nurse manager, primary nurse, physician of record, social worker, and administrator to optimize the chance that it will be honored, though one can never guarantee this.

76 Know that many of your instincts/algorithms about how to respond to common clinical problems, eg, colonoscopy for evaluation of heme-positive stool, will need to be revisited and individualized with each patient on this unit.

77 Get comfortable with prescribing morphine. Ask me for a paper. Throw out the 1940s black-and-white movie image of "She is under morphia, and it's only a matter of days." Use opiates when they are the best choice. Don't undertreat pain with tramadol when the patient needs an opiate. Put in parameters to prevent overdosing. Always include standing doses of analgesics *and* PRN doses; the usual PRN is 15% of the scheduled 24-hour dose.^{11,12}

78 If you are starting a patient on opiates, anticipate and enhance the bowel regimen. A stimulant such as senna will likely help; the standard dose is 8.6 mg by mouth daily, more if needed. You'll overshoot rarely and you will avoid trouble often.

79 Get good at bowel medicines, especially polyethylene glycol solution (MiraLax), 17 g in 200 mL of water or juice. Ask me for teaching or a paper.^{13,14}

80 Protect our frail patients: Always prescribe *Lactobacillus* if you start an antibiotic prone to cause *Clostridium difficile*-associated disease, eg, a cephalosporin, a **quinolone** (formerly a safe choice but now a leading risk), a penicillin, a tetracycline, or clindamycin.¹⁵⁻¹⁷ Do the same if you inherit a patient who is on such an antibiotic but has not had *Lactobacillus* added. Continue *Lactobacillus* for a week beyond the end of the course of antibiotic.

81 Don't give antibiotics for asymptomatic bacteriuria.¹⁸ On day 1 ask me for a paper on asymptomatic bacteriuria to help you discern the difference.

82 If the patient has had an *Escherichia coli* urinary tract infection or even asymptomatic bacteriuria due to *E coli*, consider use of cranberry capsules for the long haul; they prevent adhesion and resistance does *not* develop.^{19,20}

83 If the patient has a catheter in the urethra, learn about and talk to staff about iatrogenic hypospadias.^{21,22} Make sure that traction on the penis is avoided. Ask for help in how to tape the catheter to the leg.

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84 If possible, take the Foley catheter out soonest: it is a ticking time bomb for urosepsis, and an unstoppable source of chronic colonization with progressively more resistant uropathogens.^{23,24} It also harms both self-esteem and mobility. In 1988 the “king of urinary tract infection” called the urinary catheter “the leading cause of nosocomial urinary infections and the most common predisposing factor for preventable gram-negative sepsis in hospitals.”²⁵ It’s still true.

If in doubt about urinary retention, get some post-void bladder scans in the first days after removal of catheter to be sure of adequate emptying. If in doubt as to what volume is acceptable, look it up and then talk to me.

85 If the patient has had a distended bladder, leave the catheter in long enough to decompress it and restore detrusor tone. If despite this the patient is not emptying the bladder properly, consider whether tamsulosin would restore better ability to void. If the 0.4-mg starting dose at bedtime does not accomplish this, consider raising it to the maximal, 0.8-mg, dose.

86 Know why tamsulosin is an α -blocker preferred in aged patients over doxazosin and terazosin,²⁶ namely that it is selective for α_{1a} -receptors and thus less prone to cause orthostatic hypotension at least at its lower, starting dose.

87 Learn what the 2003-updated Beers criteria are.²⁷ Don’t use drugs from the list. If you find patients who are taking them before admission, strongly consider stopping or tapering them. Talk to the pharmacist. Talk to me. If puzzled or stuck about such a drug, call the prescriber and talk to him or her. Sometimes an exception is appropriate.

88 Recognize that information drop-off as patients cross from one locus of care to another is lethal. Do your part to gather as much information as possible on new admissions or those who have not come accompanied by adequate information. Get on the phone. Call the physician’s office. Talk to the office nurse—usually that is the key person. Routinely provide me with the name and fax number of the primary care physician and any key consultants: I will add it to the medical portion of the discharge summary, thereby increasing the likelihood that this summary will reach them and serve a function; otherwise it is an empty exercise in paperwork—and we already have too many of those.

89 In using collateral history sources such as old charts, know their limits as well as their convenience: an error once ensconced is never omitted. Just because somebody’s typo bestowed the nonexistent Von Schmerzbach’s disease on your patient in 1963 does not mean he has it.

90 In asking family members and caregivers for symptom and behavior reports, know that they may minimize *or* exaggerate *or both*, depending on their beliefs and on what they think the patient needs.

91 Recognize that all patients have peaks and valleys in cognitive performance. Best understanding of patients requires awareness of *both* as well as of the “mean elevation above sea level.” Use this image to understand why family members sometimes believe a loved one deteriorated massively when we think not, or that a medicine was calamitous when our observations suggest otherwise.

92 Participate in creating a sound, value-adding medical portion of the discharge summary, not rehashing geropsychiatric information that is in the psychiatrists’ portion, nor listing medicines, doses, and other information that will appear on the W-10, nor laboratory results that can be photocopied if critically related to *active* pathological processes. Rather, tell the story of what happened, what new problems arose, what old ones flared, what got better, what major changes in medicines were accomplished and to what results, how the BP fared, whether the fingerstick glucoses remained mostly in target range. Be complete and concise. Full sentences are not mandatory; clarity is.

93 Go easy on fingerstick glucose measurements. Most patients here do not need them 4 times per day; or need 4 times per day only for a few days. Then careful review by us usually leads to dose adjustments and a drastic reduction in fingerstick checks.

94 Don’t use sliding scales of regular insulin or at most, use them for a couple of days. They represent playing catch-up forever. Modulating dosing of basal or prandial medicine based on ongoing review is much more rational than giving an endless series of one-time supplements.²⁸

95 Own your own education. Read every day. Go see patients. Don’t write the most minimal and generic note you can, but rather stretch yourself. Don’t treat this as a job. It is a noble and learned profession and a calling.

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96 This rotation is lovely because it has no call and no weekends. But it is not a vacation. If you treat it as one, and make your principal focus getting out at 4 PM, you'll gain nothing; you'll misrepresent life as an attending, which is never that controlled in any specialty. Even the people with procedures, who sound very well compensated to internists, eg, ophthalmologists, orthopaedists, dermatologists, work very hard nowadays.

97 Believe it or not, most of your career will be as an attending and you won't be a house officer forever. My hope is to provide you toolbox items that will serve you well now and also then.

98 Don't abuse me or any other teacher: don't confuse our work ethic and love of imparting, and of going to the bedside together, with a paucity of other pressures or with entitlement on your part. Reciprocate: take good care of the service; show you care about the patients and that they are neither objects nor means to you; don't leave tasks for me that you can do competently. If I have to function as house officer to fill a vacuum so that patients are properly treated, I will do so, for the patients are why we come to work each day. But in that case I certainly won't expend additional effort to be the teacher as well. You're welcome.

99 Do your best to follow these leads. Then expect to receive strongly positive feedback.

100 More important, by utilizing these precepts you will employ your power and your effort to best purpose: you will serve and grow and learn, which are some principal lifetime tasks of every physician. Others include maintaining idealism, sustaining one's spirit, and participating centrally every day, actively and not with an asterisk because you are too busy or too tired, in the lives of the people who love you and who underpin all the good that you do. ■

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1. Rilke RM. *The Notebooks of Malte Laurids Brigge*. Herter Norton M D, trans. New York: W W Norton & Company, Inc; 1968:26-27. The passage in full reads: "I think I ought to begin to do some work now that I am learning to see. I am 28 years old, and almost nothing has been done. To recapitulate: I have written a study on Carpaccio which is bad, a drama entitled "Marriage," which sets out to demonstrate something false by equivocal means, and some verses. Ah! but verses amount to so little when one writes them young. One ought to wait and gather sense and sweetness a whole life long, and a long life if possible, and then, quite at the end, one might perhaps be able to write ten lines that were good. For verses are not, as people imagine, simply feelings (those one has early enough)—they are experiences. For the sake of a single verse, one must see many cities, men and things, one must know the animals, one must feel how the birds fly and know the gesture with which the little flowers open in the morning. One must be able to think back to roads in unknown regions, to unexpected

meetings and to partings one had long seen coming; to days of childhood that are still unexplained, to parents whom one had to hurt when they brought one some joy and one did not grasp it (it was a joy for someone else); to childhood illnesses that so strangely begin with such a number of profound and grave transformations, to days in rooms withdrawn and quiet and to mornings by the sea, to the sea itself, to seas, to nights of travel that rushed along on high and flew with all the stars—and it is not yet enough if one may think of all this. One must have memories of many nights of love, none of which was like the others, of the screams of women in labor, and of light white, sleeping women in childbed, closing again. But one must also have been beside the dying, must have sat beside the dead in the room with the open window and the fitful noises. And still it is not yet enough to have memories. One must be able to forget them when they are many and one must have the great patience to wait until they come again. For it is not yet the memories themselves. Not till they have turned to blood within us, to glance and gesture, nameless and no longer to be distinguished from ourselves—not till then can it happen that in a most rare hour the first word of a verse arises in their midst and goes forth from them."

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