the same ultimate effect on investment income, but they influence thinking in different ways. We might encourage greater effort and innovation in keeping people out of the hospital and coordinating care if we reframed its financing as positive payments for noble work rather than punitive revenue reductions. As U.S. health care financing begins again to shift risks to hospitals and physicians through bundled payments or readmission penalties, the financing of the care for our most challenging patients might be better shifted in the other direction.

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The Doctor's New Dilemma

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The woman sits perched on the end of my exam table, leaning forward, blond curls tumbling over her eyes, her precarious posture mirroring her emotional state. Though the symptom she describes is relatively minor — some diarrhea on and off — she appears distraught. She grips the table as if doing so will hold back her tears.

A psychiatrist colleague tells me that such moments, when there's a clear mismatch between what a patient says and the intensity of feeling with which he or she says it, are especially ripe for probing. But the psychiatrist sees patients for 45 minutes. I have 15, several of which have already passed, in which to address and document the woman's chief symptom: loose stool. I find myself in a quandary: Do I ask the patient why she's so upset, or do I order a culture, prescribe antidiarrheal medication, type my note, and send her on her way?

In 1906, George Bernard Shaw's *The Doctor's Dilemma* first appeared on the London stage. The play concerns a physician, Sir Colenso Ridgeon, who's discovered a cure for tuberculosis. Ridgeon's dilemma is that he has a limited supply of the medication and a small staff to administer it. He can treat only 10 patients at a time and so must decide whose life is most worth saving. Other conundrums Shaw highlights in the play's lengthy prologue are how to prevent doctors from being motivated by financial gain and how to rid the medical profession of charlatans.

In recent years, Shaw's turn-of-the-20th-century drama about the ethics and economics of health care has been seen as prescient, as prefiguring the establishment of the National Health Service in Britain and the Affordable Care Act in the United States. Even with these developments, modern Colenso Ridgeons still grapple with limited resources, inequality in access to health care, and unscrupulous or incompetent colleagues.

The dilemma I face most often as a primary care doctor, however, is not one that Shaw anticipated. The commodities I struggle to ration are my own time and emotional energy. Almost every day I see a patient like the woman with diarrhea and I find myself at a crossroads: Do I ask her what's really bothering her and risk a time-consuming interaction? Or do I accept what she's saying at face value and risk missing a chance to truly help her?

Often, the situation is not so dramatic. Say I walk into an exam room and find a patient waiting for me, reading a book. Do I ask what book she's reading? If it's one I've recently read myself, do I ask whether she, like me, enjoyed it but found it a bit longer than it needed to be? We might debate that point, and then she might start telling me about other novels her book group has read, and pretty soon we'd be having — horrors! — a *conversation*. Precious minutes wasted on useless chitchat.

But is chitchat really useless? Such conversations can generate the trust that, studies have suggested, improves health outcomes, such as control of blood pressure and relief of pain — indeed, that is essential to healing.[1] Once, when I was covering for a colleague, I saw an older woman I'd never met before. I pride myself on being able to put patients at ease, being able to establish rapport with almost anyone, but this woman would have none of it. She expressed skepticism about

everything I said. Finally, she pulled a pen out of her purse to write down my diagnosis, clearly intending to look it up later and marvel at my foolishness in proposing it.

"What a beautiful pen!" I blurted out. And it was: a lovely tortoiseshell implement with a shiny gold nib. The woman's hostility melted. She told me that fountain pens were a great passion of hers. She collected and traded them. She'd been to pen shows and pen shops all over the world. I told her that I liked fountain pens too, that in fact my husband had just bought me one for my birthday, at a shop in Dublin. Of course she knew the shop. "What make of pen?" she inquired. I confessed I didn't remember, so she asked me to describe it. Thick . . . natural wood shaft, chrome cap . . . "A Faber-Castell!" she pronounced, beaming. "That's it!" I shouted, my grin matching hers. She put her pen away without recording my diagnosis. She believed in me.

As part of a new writer-in-residence program in the internal medicine division of my hospital, I've been meeting with groups of doctors and nurses to discuss brief works of literature relevant to clinical practice. Before these meetings, I always ask whether there's a particular theme they'd like to address, and the answer, alas, is always the same: burnout.

For several groups, I've selected "Communion," an essay published 20 years ago in which Richard Weinberg, a gastroenterologist, recounts his interaction with a young woman who suffers from chronic abdominal pain.[2] At first, Weinberg finds it difficult to reach the woman, who seems hidden beneath layers of baggy clothing, vague symptoms, and stacks of results of tests ordered by exasperated doctors. The turning point comes when Weinberg, an avid cook but inexpert baker, asks the woman, who works in her family's bakery, about making pastry. As the woman expounds on the art of producing a perfect Napoleon, Weinberg observes, "For the first time her eyes came alive."

This moment of connection leads, over time, to the woman's confiding in Weinberg a painful secret. In regular meetings, which Weinberg schedules at the end of his clinic sessions, they sit and talk. Weinberg is uncomfortable playing the role of psychiatrist, but the patient will speak only with him. Gradually, she emerges from her shell, and her symptoms resolve.

At first it's not obvious how "Communion" relates to modern medical practice. Weinberg may have had meaningful conversations, but he didn't have "meaningful use." In 1985, free from the shackles of the computer screen, Weinberg faces only one obstacle in engaging the troubled young woman: his own willingness to do so. His leisurely conversations with her seem as quaint to us now as black bags and glass hypodermics.

Still, the moment when Weinberg takes the plunge, when he asks the woman about pastry, seems very familiar. It's a moment we have all inhabited and, all too often, pulled back from — a threshold we fear crossing. We imagine ourselves, now, in Weinberg's place, and we recognize a double bind, a new doctor's dilemma: if we ask about the pastry, we fall hopelessly behind in administrative tasks and feel more burned out. If we don't ask about the pastry, we avoid the kind of intimacy that not only helps the patient, but also nourishes us and keeps us from feeling burned out.

The woman with the blond curls can keep back her tears no longer. She gestures to her midsection and sobs, "I can't hold on to anything!"

I am struck by her choice of words, by the metaphorical power of her cry. In the past, she's told me of her difficulty maintaining relationships, of her loneliness. I've recommended psychotherapy, but she's declined. I consider pointing that out to her, suggesting that her diarrhea might be an eloquent manifestation of her psychological pain. But 25 minutes have passed, and there just isn't time to open that door.

I order the cultures, prescribe an antidiarrheal drug and some dietary modifications, briefly mention psychotherapy again, and leave the room. Then I sit at my workstation to document and bill for our encounter, perched at the edge of my seat, on the verge of despair.

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