‘The House of God’: reflections 40 years on, in conversation with author Samuel Shem

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Abstract

The House of God is a seminal work of medical satire based on the gruelling internship experiences of Samuel Shem at the Beth Israel Hospital. Thirteen 'Laws' were offered to rationalise the seemingly chaotic patient management and flow. There have been large shifts in the healthcare landscape and practice since, so we consider whether these medical truisms are still applicable to contemporary National Health Service practice and propose updates where necessary: People are sometimes allowed to die. GOMERs (Get Out of My Emergency Room) still go to ground. Master yourself, join the multidisciplinary team. The patient is the one with the disease, but not the only one suffering. Placement (discharge planning) comes first. There is no body cavity that cannot be reached with a gentle arm and good interventional radiologists. Fit the rule to the patient rather than the patient to the rule. They can always pay you less. The only bad admission is a futile one. If you don't take a temperature you can't find a fever and if you are not going to act on it, don't do the test. Show me a BMS (best medical student) who ONLY triples my work, and I'll show you a future Foundation Year 1 doctor (FY1) who is an asset to the firm. Interpret radiology freely, but share your clinical findings with the radiologist and in a timely fashion. Doing nothing can be a viable option. These were developed in conversation with Samuel Shem, who also offers further insight on the creation of the original laws.

“The House of God” is a widely read satirical novel—**in a recent list of “The Ten Best Satires of All Time” it was Number 2 (Publishers Weekly). The novel** is based upon the gruelling internship experiences of Dr Stephen Bergman at the Beth Israel Hospital. Writing under the pen-name of Samuel Shem, he offered an uncomfortable focus on the conditions under which junior doctors trained, the wider American healthcare system and some unpalatable coping strategies required by those junior doctors.

When first published in 1978, it served to highlight many similarities and differences between American and British medicine, including healthcare culture and funding, and how those impacted both health professionals and patient experiences. Much has changed within medicine on both sides of the Atlantic since, in part due to the self-reflection forced upon the profession by pieces such as this. However, the landscape itself has also shifted seismically with a different patient profile suffering from ever-spiralling disease burdens, unparalleled diagnostics and new treatment paradigms in most fields making some of the approaches detailed within the House of God seem antiquated.

Threaded through the darkly-humorous, often emotionally raw and at times raunchy story, Dr Bergman imparted thirteen poignant yet comedic "Laws of The House of God". Here we consider whether they still hold true and where necessary reinterpret them for the life in NHS hospitals today. We go one step further, however, in including the author in this conversation.

Law I: GOMERs don't die

GOMERs (an acronym for Get out of My Emergency Room) are patients who usually have a collection of incurable chronic medical conditions tied with advancing age and an indeterminate presentation. They form a large component of the patient cohort admitted to hospital in the narrative and arguably still do today. There is a prevailing culture both within medicine and wider society that people are not allowed to die without all possible interventions being attempted first. Furthermore, clinicians are concerned about being considered "ageist" and families sometimes wish to "try everything" no matter the cost to quality of life. However, the recognition of inevitable death is a crucial and understated skill which can make all the difference to patients and their families. This is certainly an area which would benefit from better formal undergraduate and postgraduate education – a dignified natural death is allowed.

We suggest Law I: People are sometimes allowed to die

Shem replies: **Agree with your update. However in the novel, gomers always could die, and in fact were allowed to die, but never did. Better allowing might help.**

Law II: GOMERS go to ground

Inpatient falls in hospitals represent a significant patient safety and governance issue which are often the focus of nationwide initiatives and audits. There is often a difficult balance being struck between restricting patient's liberty and ensuring safety to avoid slips, trips and falls. Although most trusts have a preventative "fall safety package" in some guise, it is impossible to avoid all accidents with the current levels of staffing and alien (to patients) ward environments with hard and often slippery floors. Therefore, accident reporting and root cause analysis are most likely to yield any further gains to be made in this field. Nevertheless, optimisation of population bone density might help them bounce back (we jest –but would regardless prefer to reduce nosocomial harm).

We suggest Law II: GOMERs still go to ground

Shem replies: **Yes, this law seems eternal. In the novel our logical solution, which only lasted a night, was to put the mattresses on the floor. In fact recently I read a serious essay on the House that cites this solution, employed (he does not say where) in several places, with excellent results.**

Law III: At a cardiac arrest, the first procedure is to take your own pulse

Most junior doctors are initially understandably terrified of being confronted alone with an unresponsive patient but staff-education, training courses such as ALS and formation of easily-memorable treatment algorithms have immensely improved the management of acutely unwell patients since the '70s. However, the point can be broadened as medicine is far more team orientated than it ever has been. Being an effective member of the multi-disciplinary team (MDT) or Inter-Professional Team (IPT), and working well with a diverse set of colleagues despite the mounting pressures in an ever more integrated service is optimal for patient outcomes, not just at cardiac arrests. Sometimes doctors need to assume a leadership role, and sometimes they need to apply their skills as a team member. A controlled pulse and a cool head no matter the circumstance is more crucial now than perhaps it ever has been.

We suggest Law III: Master yourself, join the MDT (IPT)

Shem replies: **What can I say? This is probably the most quoted Law of all, and the most useful. And not only in medicine. I would revise it only as: "At a cardiac arrest *or at a scary time in your life,* the first procedure etc.",**

Law IV: The patient is the one with the disease

Although it is undeniably true that the patient is the one with the disease (as long as it's not infectious), the impacts are far-reaching. Usually, it has a substantial impact on families and carers alike and therefore communication both with the patient and those close to them is more important than ever. However, healthcare workers including junior doctors involved in patient care can also become secondary victims and at times blame themselves for unavoidable adverse outcomes. In these times it is worth remembering the inevitability of the natural history of disease, no matter our interventions. It is also worth recognising the distress, whether as a step to reconciliation, or as a trigger to help.

We suggest Law IV: The patient is the one with the disease, but not the only one suffering

Shem replies: **Soon after I wrote this law, recovering from the war zone of The House of God, and growing up a bit, I was bothered by this, along the lines you mention. This law, as written, I have come to call 'the doctor's disease,' saying that I, a doctor, are different than, and isolated from, you, the patient. It's treating the patient as an object and, usually, is caused by our stress, our fear, anger and even burnout—totally understandable, as protection. We are unable to put ourselves in the other person's shoes, feelingly—i.e., feel empathy. Since then I've come to believe deeply that the danger in being doctors—and being a person is this: Isolation is deadly, and good connection heals. Now I would rephrase it: 'The patient is not the *only* one with the disease." The disease we share is, yes, suffering.**

Law V: Placement comes first

Procuring suitable discharge destinations and adequate social care is one of the biggest challenges currently facing the NHS. At any one time at least 10% of acute hospital beds are

occupied with patients not requiring further medical management and awaiting safe discharge. Although short term financial woes may have been eased with the proposed council tax raises, care agencies are folding at a record rate. There is as of yet no coherent plan; meaning that placement for patients fit to leave hospital is perhaps the second most important law. It is hard to see how this will not continue to be a major issue for the foreseeable future. For elective admissions, discharge should be planned prior and for emergencies the discharge planning process should be instigated as early as possible – even when there are still outstanding acute medical issues.

We suggest Law V: Placement (Discharge Planning) comes first

Shem replies: **While this law was focused on gomers—whose bed in the nursing home often was sold on the way in—now, in the horrifically-profit-driven American medicine, it is more true than ever. It's based on some jerk consultant who took it from the hotel model: TOSS, meaning Toss Out By Noon. More turnover of beds, more money for the "Billionaire class." If you don't discharge by noon, a commando squad of tight people in sharkskin suits and a nurse march down the hall to kick your ass.**

Law VI: There is no body cavity that cannot be reached with a #14 gauge needle and a good strong arm

Since 1978 there has been an explosion of interventional diagnostic and therapeutic techniques which has resulted in radiologists taking over management of large domains of surgery (from abscess drainage to endovascular approaches with arterial stenosis). Furthermore, many biopsies are now increasingly performed using ultrasound or CT as a guide. The old adage of 'see one, do one, teach one,' has largely been consigned to the history books, especially when it comes to invasive procedures.

We suggest Law VI: There is no body cavity that cannot be reached with a gentle arm and good interventional radiologists

Shem replies: **I like "gentle". I've read that the AI—Artificial Intelligence—people (and why would we want Artificial intelligence, rather than Human intelligence?), say that soon doctors will be unnecessary—especially radiologists, including interventional. Oh yeah? The ray guys report on what they find is hedged by fear of lawsuit. If you want to know the truth. You have to go talk it over with them. And when the AI guys get their cancers, do they really prefer to be with a machine than with a real live doctors. Or maybe they don't notice anymore.**

Law VII: Age*BUN = LASIX dose

Drug doses are based on more safety and efficacy evidence in the modern era and there is easy access to resources such as the BNF (including online) which leads to fewer customised dosing regimens. Nevertheless, there has been an explosion of clinical decision rules, which are

validated mathematical tools to help guide common clinical decisions. Well-known examples include the Ottawa Ankle Rules, Well's Scores for PE and DVT as well as CURB-65 risk stratification for community-acquired pneumonia. These are extremely useful when used in the same population and under the circumstances that they were validated in but often have strict exclusion and inclusion criteria. Use in individuals who don't fit these criteria leads to evidence-free decision making. Furthermore, they function to aid but are not a substitution for clinical acumen – a patient with a community acquire pneumonia and CURB-65 score of 0 (traditionally classified as low risk), with severe underlying lung disease and an oxygen requirement will require further workup and most likely admission despite the guidelines suggesting home-based care would be more appropriate.

We suggest Law VII: Fit the rule to the patient rather than the patient to the rule

Shem replies**: I didn't know that in Ottawa the Ankle Rules, but it sounds sexy. There is no scientific basis that I know of for Law Number VII—but it works every time.**

<u>Law VIII: They can always hurt you more</u>

Although this originally referenced violence against staff by patients and families, which remains an important issue, the widest reaching modern interpretation probably results from a seemingly endless political drive for greater service provision with little additional investment in either services or staff.[1] This phenomenon is by no means restricted to doctors. Financial reward is the chief of several ways in which doctors can feel less valued, whether as professionals or as people.

We suggest Law VIII: They can always pay you less

Shem replies: **The on-call hours cap in the US, in response to the Libby Zion case, made internship much less exhausting, and so the hurt is less. The real hurt is the fact that, in my survey of interns, they spend at minimum, 89% of their shift on call in front of some screen or other, leaving little tie for patients. This is the great crime of "modern" medicine. I'm amazed that the new doctors take it—this drone work, clerical work, really—*that's* what hurts them more, now.**

<u>Law IX: The only good admission is a dead admission</u>

In some audits, up to 10% of admissions die within 24 hours of admission[2]. Surveys reveal that the large majority of people would prefer to die at home rather than in hospital[3]. Therefore, early identification of those in which treatment will prove to be futile and thereby avoiding admission should be a key objective. This would improve patient and family experience at the end of life. Improving triage prior to presentation at hospital is a major challenge – especially with the move towards algorithm-driven telephone-triage services like NHS 111 and with national awareness campaigns. Better information flow between primary and secondary care services and empowerment of decision making prior to presentation would be helpful.

We suggest Law IX: The only bad admission is a futile one
Shem replies: **Agreed. That Law came out of total exhaustion, and, significantly, is a paraphrase of the racist, genocidal extermination at the founding of America: 'The only good Injun is a dead Injun."**

Law X: If you don't take a temperature you can't find a fever

Accurate and thorough basic observations are crucial to good clinical care so this law refers to requests for unnecessary diagnostic tests. These may be due to defensive practice, lack of experience and confidence, idiosyncrasies relating to individual practice or poor understanding of the significance that a result represents and whether clinical management would change. Aside from causing unnecessary patient discomfort and increasing the risk of generating false-positive results, over-use of diagnostic tests are an enormous waste of valuable healthcare resources. "Routine" inpatient clinical tests are often for the benefit of clinicians – if you would not be prepared to justify the necessity of this test to an angry and articulate tax-payer, don't do it!

We suggest Law X: If you don't take a temperature you can't find a fever and If you are not going to act on it, don't do the test

Shem replies: **Good. In America, it's called "CYA" (Cover Your Ass) Medicine. Without tort reform, this waste of money and effort will keep on.**

Law XI: Show me a BMS (Best Medical Student) who only triples my work and I will kiss his feet

This law is not outdated. Medical students are no longer required to be a formal part of healthcare service provision, but are nonetheless expected to learn in clinical settings. The duty to teach is recognised in large subsidies received by teaching hospitals. However that duty is widely delegated to junior (non-consultant) doctors who have to factor teaching students into their clinical workload. When students learn proactively, and offer moral and practical support to those whom they shadow, this can be a joy and reduce the sense of loneliness and disconnection felt by junior doctors. When students are unenthusiastic or have not put effort into self-directed learning this can seem a tiresome chore. This is a professional relationship however and both doctor and student contribute. Unless they know what's expected students cannot rise to the occasion. If you do not invest time in showing them how to do something, their ability to help is limited and their development towards the Foundation Years is limited. If you worry that you'll teach them a pile of useful things which they will pay back in their next attachment but not yours, maybe you should encourage all your colleagues to be better teachers too!

Show me a BMS who ONLY triples my work, and I'll show you a future FY1 who's an asset to the firm

Shem replies: **Any good connection is mutual. If it ain't mutual, it ain't good. The junior doctor/student connection is, at best, mutual—if it's successful, *both* come away with "Five Good Things: increased zest or energy, increased knowledge of self and of other, increased valuing of self and other, increased sense of power and the ability to take action (in medicine and relationship), and a desire for more connection." Connection comes first.**

Law XII: If the radiology resident and the medical student both see a lesion on the chest x-ray, there can be no lesion there

The implication of the above Law is that neither the radiologist or the medical student may have actually examined the patient. Plain radiology is often not looked at in a timely fashion except by the referring doctor themselves. Furthermore it needs to be interpreted within the context of the clinical presentation and with access to previous images for comparison. In some hospitals, out of hours radiology is now being reported remotely without easy access to clinical staff. There is substantial intangible value in having face to face conversations with radiologists and therefore should be available both in and out of hours – experience can temper overzealous diagnosing (and associated costs). Knowing about the patient (or dare we say having seen the patient) can also lead to more accurate interpretation of imaging and other testing modalities.

We suggest Law XII: Interpret radiology freely, but share your clinical findings with the radiologist and in a timely fashion

Shem replies: **Agree. If there is any doubt about the information the radiologist—and/or student—is presenting, realize that it may be the XRay guy CYA-ing on the official report, and the student doesn't know about that parameter, or pressure. The "real" will always come out if there is a good connection. General LAW in medicine and life—whether you're trying to get information from a patient or trying to be closer with a person in your outside relationships: "Connection comes first. If you're connected, you can talk about anything; if you're not connected, you can't talk about anything." In a good connection with XRay and student, the real will always appear, clearly, with no fuzz on it.**

Law XIII: The delivery of good medical care is to do as much nothing as possible

Law XIII may be timeless because 9% of all patients have an adverse event whilst in hospital of which 43.5% are believed to be preventable[4]. There are notable parallels between Law XIII, over-investigation (Law X) and over-treatment (Law I); iatrogenic harm is often done with the best of intentions. Circumstances can dictate that active monitoring may be best for the patient in front of you, although for many it remains difficult to accept when you are unable to provide an intervention of benefit for a patient.

We suggest Law XIII: Doing nothing can be a viable option

Shem replies: **When I came to writing this law, almost 40 years ago now, I recall that I first wrote: "The delivery of good medical care is to do nothing." And then—rare for me in those days—I had a kind of 'flash' and stopped, and added, "—as possible." This makes all the difference in the world, and, humbly I would suggest that this is the most valuable Law and would not change it. It shifts the burden from starting out without a drug or a needle in your hand ready to go for it; rather it says 'do nothing, but examine, test, and then—oh my!—breathe, in and out is preferable--take time to do as much nothing as possible except considering things—not alone but at some point with others—and the answer will come to you. You will then know what is essential to do, one step above 'nothing', usually, sometimes two—or even ten. Note that now, with the disease of facing screens 80% of your time, this means you may be the only one in the long line of fellow doctors click click clicking instead of considering, and it can be lonely, but it is called humane medical care. Therefore, I would not alter the wording of this at all.**

The original "House of God" title references to the Beth Israel Hospital, where the author trained, in an era notable for the absence of patient centred care. There has since been a paradigm shift in medical thinking towards greater patient-centric decision making. This should be reflected in an updated title; "The House of the People" or perhaps "Man's best hospital".

Many similarities remain between the original and updated Laws, highlighting that many components and challenges within Medicine are both timeless and communal to all healthcare systems.

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