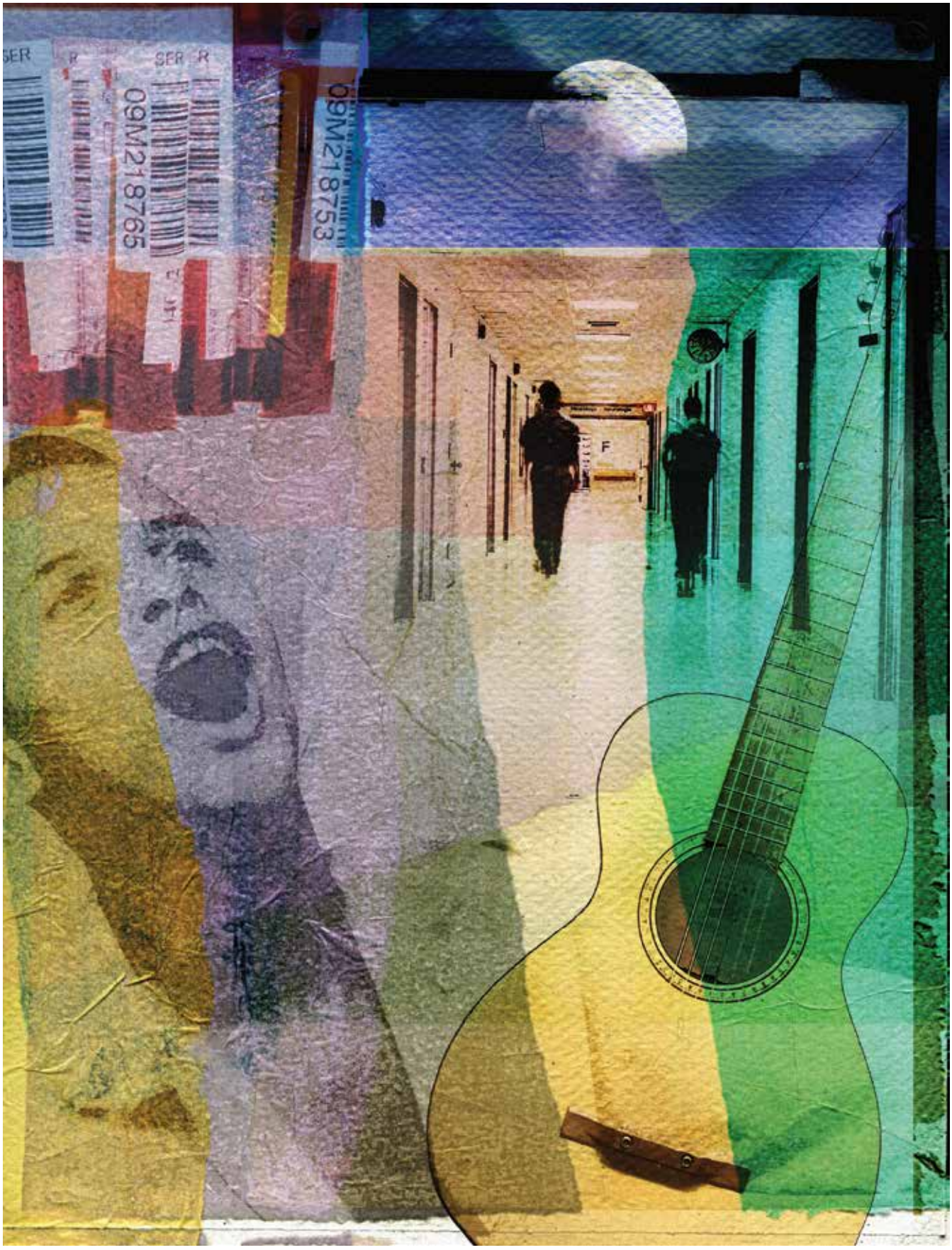
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What Singing for Blood Taught Me

ABRAHAM M. NUSSBAUM, MD, MTS
Chief Education Officer and Designated Institutional Official at Denver Health

"I can't get 'the stick.' She won't let me near her."
The third phlebotomist of the day walked out of Renee's room with an unused needle.

Unless this patient's blood could be drawn to test it, I would have to discontinue clozapine, the only medication that reduced Renee's commanding voices to tolerable whispers. When she took clozapine, she could live with her brother. When she went off it, she walked alone on the streets. To continue prescribing, I would need to be the one who drew near her, but like a vampire.

I asked the phlebotomist for the needle and the medical student with me to turn on her smartphone. We were going to sing to draw blood from Renee.

SINGING TO UNDERSTAND

The formal strategies for medical care and training are verbal and procedural. Attending physicians like me assess how patients are doing and how much trainees know by asking questions: "How is your medicine treating you? How frequently does clozapine induce agranulocytosis?" Then we verify by asking patients and trainees alike to perform procedures of various sorts: "Can we sample your blood? Will you examine the patient to assess for adverse effects?"

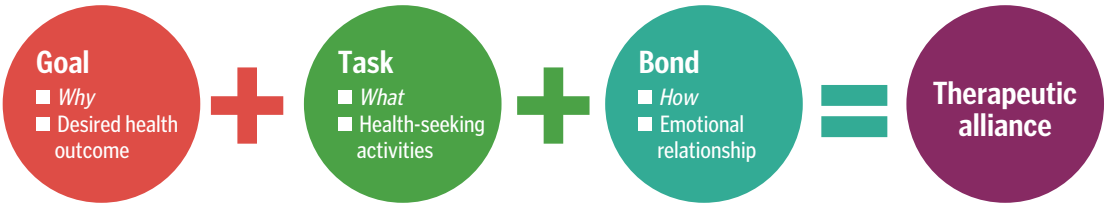
The informal strategies develop your senses to see how a person sticks herself in the world. Medical professionals seek understanding of a person by sensing their mood, memory and even their ability to carry a tune. You learn more about depression by how your own mood darkens when listening to a depressed person. You learn dementia by the smell of an older woman no longer able to bathe. You learn mania by the sound of a young man sing-shouting his favorite lyrics.

In the psychiatric wards where I meet people as patients, some songs crescendo into agitation. When the agitation is sustained into acting out, a nurse often messages me for medications to chemically calm a patient. Sometimes, I prescribe. Sometimes, I return with a music therapist who can calm the patient by playing along.

I work with Maria Schimpf, a music therapist who can match the pitch of her voice and the rhythm of her guitar to the sound of an agitated young person. A song or two in, she often guides them to a more stable rhythm. Her songs often work as well as any of my medications, but they are guaranteed to make the encounter more humane, even for vampires like me.

Schimpf was off on the day Renee was declining blood draws. (I am using a pseudonym for this patient to respect her privacy.) I cannot carry a tune, but medical training teaches you to do what needs to be done. I borrowed one of Schimpf's tricks, asking Renee what song we could sing together. She picked the Chi-Lites' "Oh Girl." The med student queued it up on her phone.

I didn't know the song, but I knew the anatomy.



Adapted from Psychologist Edward S. Bordin's Therapeutic Alliance

I placed the tourniquet as the song started. The smooth harmonies told about trouble when alone. Renee's face settled. She sang along. Her arm relaxed to the sound of familiar voices. I cleaned her elbow, sang along to the lyrics in the video, and then threaded the needle into her vein. We had the blood.

BUILDING 'DIAMOND' BONDS

Psychiatrists like me learn to sit with someone, even sing with them, to build a relationship that allows us to help a patient achieve health outcomes she could never achieve alone. Through experience, we learn to build alliances with patients through the three components of the therapeutic alliance (see graphic above).

The first is a goal, a health outcome, that a patient and a clinician work toward together. The goal is the *why* of a clinical relationship, and I check in on our progress toward it every time I see a patient. The second is a task, a health-seeking activity, that a patient pursues as a step toward her goal. Each task is the *what* of a clinical relationship, the activities that we do together and apart, like an exercise regimen or a cognitive-behavioral workbook. The third is a bond that a clinician develops with a patient. The bond is the *how* of the clinical relationship, the way we relate together. A bond can be challenging, supportive or even a sing-along.[1]

I tell patients and trainees it's like high school chemistry. A pile of coal and a shining diamond are both made of carbon; what distinguishes them are the bonds between the molecules of carbon. If you want to make coal with a patient, studies show that you avoid eye contact, stand over a patient, cross your arms and ask a series of close-ended questions. I call it being a psychiatric robot when I ask a patient something like, in one great rush of words, "Are you experiencing a headache, chest pain, shortness of breath, nausea, thoughts of suicide, depressed mood or an adverse medication effect?" If you want to make a diamond, sit with a patient, let her tell her story, reassure her, respect her opinions, examine her gently and ask more follow-up questions.[2] If you form a good alliance, patients across many mental and medical illnesses experience approximately 10% better health outcomes, when controlling for all other factors, while clinicians experience greater joy in their work.[3]

I removed the tourniquet and needle, but held on to Renee's arm as she sang on.

THE TRANSFORMATIVE EXPERIENCE OF BECOMING A PHYSICIAN

After we drew Renee's blood, the medical student shared that she'd neither heard of the Chi-Lites nor learned to draw blood. She asked how I knew.

I told her I first heard the Chi-Lites while volunteering with the Sinsinawa Dominicans at a respite center for medically ill and injured homeless people in the west of Chicago. We lived in a Dominican priory, where our days began and ended chanting hymns, but we spent the middle of our days on the streets, collecting and driving homeless people to and from hospitals. Many of the people I collected tuned the homeless center's van to the station playing "dusties," a genre of smooth soul songs from the 1960s and '70s. The Chi-Lites were in heavy rotation. The experience of learning dusties with patients and hymns with the friars led me to medical school. I wanted to learn how to sing along with patients.

When I began training a quarter century ago, medical students were taught to read their own X-rays, place their own lines and draw blood from their own patients. Medical students learned most procedures while taking overnight call with whatever clinical team they were assigned. This could involve every second night in transplant, every third night in trauma and every fourth night in the medicine wards. If you worked hard through the nights, the team allowed you to "get" a procedure.

Seeking experience, I learned to draw blood and run tests. I learned to ask penetrating questions and expect intimate answers. I learned that I could listen well and save a life. I learned to deliver evidence-based care while sleep-deprived. The experiences exhausted and energized me, unmade and made me. I began medical training wanting to be a surgeon, but ended up as a psychiatrist.

Medical students often describe the serial immersions of the clinical year as finding their place in medicine. I told the med student that for me, it was more like vampire training. I shared with her that a decade after residency, I read the philosopher L.A. Paul's *Transformative Experience*. The book opens: "Imagine that you have the chance to become a vampire. With one swift, painless bite, you'll be permanently transformed into an elegant and fabulous creature of the night. As a member of the undead, your life will be completely different. ... if you pass up this opportunity, you'll never have another chance. ... To make a choice like this, you'd want to make the best decision you could."

Paul writes that when facing a choice to become a vampire, you are facing an intense, overwhelming and life-changing choice, one that is irreversible. You choose an experience that you know will fundamentally change you, but you cannot know how until after the experience. It's a catch. You know you will be a different person on the other side, but you cannot know how different.

There is no way out but through.

You may think the decision can be made rationally by gathering information, weighing options and selecting the one that best fits you. Paul says that works for many choices, but not when you are choosing to be transformed.

Paul includes additional examples of experiences as transformative as the metaphorical one of becoming a vampire: marrying, birthing a child and training as a physician.[4]

Vampires, spouses, parents and physicians: All are transformed in the night. It is at night that vampires bleed others, while spouses talk as they drift off to sleep, only to wake up to soothe crying children. Becoming a physician overnight variously involves each act: bleeding patients, helping them sleep, tending to crying children, and, along the way, mending those you can.

Being a physician changes how you stick yourself in the world. I told the med student that while volunteering with the Dominicans and discerning my future, I read a book by the Catholic physician turned novelist Walker Percy. Toward the end of the novel *The Moviegoer*, the protagonist, Binx Bolling, decides to go to medical school and explains it by saying, "There is only one thing I can do: listen to people, see how they stick themselves into the world, hand them along a ways in their dark journeys and be handed along, and for good and selfish reasons."[5] The quote has stayed with me. A physician sometimes cures, even fixes, but all our patients eventually diminish and die. Most of what we can do is listen to people, see them, acknowledge their journey, and travel a little way with them, for good and selfish reasons.

Being a physician is often like being a vampire. A physician engages in acts that are assaultive outside the physician-patient relationship: dissecting bodies, performing intimate examinations, and prescribing mind- and body-altering medications. Society grants us the right to perform those acts to improve the health of the sick. In return, it asks physicians to be different in the world.

A physician sometimes cures, even fixes, but all our patients eventually diminish and die. Most of what we can do is listen to people, see them, acknowledge their journey, and travel a little way with them, for good and selfish reasons.

I admitted to the med student that I rushed the process, going through all of Paul's transformative experiences in a single year. During my clinical year, my classmate and I married, welcomed our first child and selected our future specialties. We both underwent triple vampire training.

We both chose a career in medical education so we can help the next generation navigate their own transformative experiences. My wife runs a family medicine residency at a local Catholic hospital. I don't work in a Catholic system, but I still

try to teach the kinds of songs I learned with the Dominicans. At Denver Health, my team oversees the experiences of the 1,200 resident physicians and 2,000 students in 34 professions who train annually at our hospital. At the University of Colorado School of Medicine, I teach medical students the basic sciences underlying psychiatry. I tell each trainee I meet they are going through a transformative experience. When they smell a festering wound, they will not turn away. When they see a person suffering, they will sit with them. They are becoming the kind of people who respond to the needs of the ill. They have chosen their transformative experience, and now they must live it out. Just like vampires.

CHANGING EXPECTATIONS

But a medical student may now graduate without ever learning to draw blood.

The transformative experience has changed dramatically in the 15 years since I finished training. Women now make up most applicants and entrants to medical school. Twenty-nine allopathic and 17 osteopathic schools have opened since 2010, many of which are experimenting with curricula.[6]

Seeking an understanding of how these changes are altering medical training and practice, I spent the past five years following a group of medical students. I watched them in clinics, operating rooms and emergency departments. I sat in as they learned in small and large groups. I learned what works and what does not with today's learners, then published a book about their experiences and the future of medicine.[7] I saw that medical students no longer routinely learn to draw blood, many hardly take call, many think it daft that my wife and I welcomed a child during training, and some resist the idea that medical education should change you, for good and selfish reasons.

Some practicing physicians tell reporters that the changes in future physicians' expectations amount to a generational gap between the physicians of today and those of tomorrow, which threatens the future of the profession.[8] After hours at medical education conferences, colleagues trade stories of emergency medicine residents who ask to never work nights and weekends; psychiatry residents who decline to see suicidal patients because it triggers their own trauma; family medicine residents who describe medical education as a human rights violation; and other instances of young physicians seemingly prioritizing their well-being over a patient's. *The New England Journal of Medicine* has published a series of essays by a leading physician about the growing generational differences between physicians, which directly ask if physicians and trainees now expect such different things from medicine that we are no longer pursuing the same calling.[9-11]

I still have hope for our calling because when I ask most medical students and residents, they still want to learn how to sing with patients.

Which brings me back to my patient, Renee. We sang on to the song's final verses, which discussed helpless people and useless tears.

Singing with her, I thought about all the conversations in the last few years about what's gone wrong in medicine. Is it burnout? Compassion fatigue? Moral injury?[12-14] I appreciate the attention to the challenges physicians and other clinicians face, but find these conversations discouraging. Attending another CME event or conference keynote about burnout feels like nothing more than an opportunity to cry my own useless tears.

After all, physicians like me are far from helpless people. I find it unhelpful to describe an experience I chose — even one that challenged me before it transformed me — as traumatic. I find it disobliging to account for an experience that taught me useful skills as injurious. I find it rude to describe residency as a human rights violation when the people I meet as patients are experiencing profound illnesses and injustices.

Yet, there are days when doctoring seems too much. Patients say our care is too costly, too complex and too difficult to access. I agree, and admit that I am tired of the documentation chores, the administrative interferences and the bureaucratic hoops. I feel less than human after some clinical days, even as I am engaging in one of the most human tasks: caring for another person.

Renee squeezed my hand. The song was over. The doctoring goes on.

LEARNING TO SING

I learned from watching today's students that there are better ways to engage all generations of physicians.

First, I don't believe it's truly helpful to treat health care providers as heroes. During the COVID-19 pandemic, it became fashionable to praise health care workers as heroes. When we

We need to train clinicians for a lifetime of caring for others, without risking their own lives. We don't need to save one day; we need to serve a community for a generation or more. That's not hero work; it's the day-to-day work on the other side of a transformation, the marriage after the wedding, the parenting after the birthing.

left hospitals, we were serenaded with cheers and whistles. Someone graffitied the side of our hospital with painted letters spelling out "HEROES." It felt good for a week or two, but as the pandemic wore on and its recovery never arrived, we were tired of being called heroes.

Eventually, the hospital's maintenance team blasted the letters off, one at a time. As they washed away, I thought about how heroes risk life and limb while performing extraordinary feats, all to save the day. We need to train clinicians for a lifetime of caring for others, without risking their own lives. We don't need to save one day; we need to serve a community for a generation or more. That's not hero work; it's the day-to-day work on the other side of a transformation, the marriage after the wedding, the parenting after the birthing.

Second, teach us from two textbooks. For the past century, physicians like me have been trained in the textbook of the body. Our first patient was a cadaver. Our task was to memorize the bones, vessels, muscles and organs of the body and then select one distinct area of it that we specialized in for the rest of our careers. It worked for a time, but today our patients are dying from chronic diseases. Our gains in life expectancy are reversing.

We need physicians who know the communities in which they live and serve. It starts with recruiting medical students with more life experience before medical school, whether because they know illness personally, served in the military, worked a previous job, learned to speak multiple languages, immigrated from another country, studied disciplines beyond the basic sciences, come from an underrepresented background, parented a child or some other experience that prepares them to be transformed. During training, it means integrated care models, longitudinal training, home visits, more teaching health centers, rural training programs and other experiences that transform medical students.

Third, engage us in therapeutic alliances. Instead of asking us to rate our burnout, ask physicians and other clinicians about our own therapeutic alliance with our patients and our organization. Dozens of validated rating scales exist for assessing the therapeutic alliance and can be easily adapted for clinicians.[15] Many industries have adapted such measures. (When you push a smiley button to rate your service, it's built on therapeutic alliance measures.) I don't think physicians are suffering from burnout, compassion fatigue or moral injury so much as we are suffering from loss of alliance, agency and purpose. What we need is for medicine to be a kind of magic again, the magic of learning to sing along with other people.[16] We can rebuild upon the insights from positive psychology so that when we ask people what's going well and what can be better, we engage their alliance, agency and purpose.

Finally, be more human. Many of the things I memorized in medical school are no longer necessary in the world of artificial intelligence (AI). Soon, many of the things I do, like hours of documentation, may also be replaced by AI. If a psychiatric robot can do those portions of my work, I am grateful. What will remain is being human: the parenting, the partnering and the doctoring.

Today's medical students and tomorrow's physicians don't have to learn to draw blood, but they do have to learn to sing with patients like Renee.

DR. ABRAHAM M. NUSSBAUM is chief education officer and designated institutional official at Denver Health. At the University of Colorado School of Medicine, he is a professor of psychiatry and an assistant dean of graduate medical education. He has authored six books, most recently *Progress Notes: One Year in The Future of Medicine*, which follows seven medical students during their clinical training.

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