

economic status can justify. But they also hamper efforts to improve the emotional health and wellness of clinicians. When physicians have been expected to be self-negating, have been stigmatized for being sick, and have been held personally responsible for their wellness, efforts to address emotional health have targeted individual clinicians.

Recent reports from the National Academy of Medicine emphasize the problems with relying on individual interventions alone and recommend a systemic approach to addressing clinician burnout and well-being. These calls are noteworthy, given the historical tendency to hold physicians personally responsible for tolerating occupational stress.

An alternative is to recognize physicians as workers who, like

others in health care, deserve basic rights and adequate conditions. The historical obstacles have allowed health care to subsist on the goodwill of its employees rather than reckoning with structural problems. Recognition of these persistent barriers can spur structural policy innovations that numerous North American and European groups have identified, such as adopting work-limit protections, making occupational health a top-level priority on par with patient safety, and addressing social determinants of both patient illness and clinician burnout (see table). By attending to the lessons of the past, we can envision a better future for patients and their physicians.

Disclosure forms provided by the authors are available at NEJM.org.

From the Centre for History in Public Health, London School of Hygiene and Tropical Medicine, London, United Kingdom (A.A.-F.); the Center for Medical Humanities and Social Medicine, Johns Hopkins University, Baltimore (J.D.M.); the Program in the History of Science and Medicine, Yale University, New Haven, CT (S.V.S.); and the University of Michigan Medical School, Ann Arbor (S.V.S.).

This article was published on January 1, 2022, at NEJM.org.

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DOI: 10.1056/NEJMp2112095

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The Doctor's Oldest Tool

Elvin H. Geng, M.D., M.P.H.

I first came across Mr. B. while reviewing charts for new patients in my primary care HIV clinic. Even in a public hospital where many patients were down-and-out, his case struck me. He lived in a single-room-occupancy hotel and had a history of homelessness. He'd received an HIV diagnosis years before and had managed occasional contact with the health care system but had never started HIV treatment. He adamantly maintained that HIV was not the cause of AIDS and that the medications were useless at best and toxic at worst. He'd been hospitalized several times recently with life-threatening diagnoses, pneumocystis pneu-

monia and pneumococcal sepsis among them. He'd come to the clinic for urgent care and post-discharge visits, but never developed a lasting bond with any clinician.

Mr. B. looked thin and worn when we met. After discussing his recent hospitalization, I fell into a common trap. I brought up HIV treatment, and he confidently declared that HIV does not cause AIDS. I mentioned robust research, but he quoted early reports on HIV — citing journal, date, and author — and pointed out subtle inconsistencies. He asked me whether I knew a seminal paper from the 1980s, and I had to admit I'd never read it in

detail. Asked why he thought he was sick, he sounded somewhat fearful but largely resigned: "I don't know." When the encounter ended, I put in a prescription for antiretrovirals and said, "If you change your mind, they are there for you to pick up." He chuckled.

Two weeks later, he didn't show for his follow-up visit, and the social worker said she would call him. Several months later, an inpatient team emailed me saying he'd been admitted with an advanced systemic malignant condition. The oncologists believed chemotherapy would be futile without HIV treatment, so he was being discharged to hos-

pice. The life events documented in his chart suggested a difficult time: marginal housing, no clear relationships, psychiatric encounters but no diagnosis, a history of trauma, limited schooling, trouble with the law. I was amazed that he'd perused so many scientific journals.

AIDS denialism has always been part of the HIV crisis. In the 1990s, virologist Peter Duesberg vociferously denied that HIV causes AIDS. Playing to homophobic tropes, he suggested that elements of the "gay lifestyle," such as drug use, led to immunodeficiency. The medical establishment shunned Duesberg, but his theories spread widely. When HIV raged through South Africa, former President Thabo Mbeki subscribed to Duesberg's views and delayed public health treatment, costing hundreds of thousands of lives. Prominent U.S. acolytes of Duesberg died of AIDS, and some let their children die rather than take proven treatments. Duesberg wasn't the sole source of dissent. The Black American community's justified mistrust of the medical establishment led some to believe that the Central Intelligence Agency had created HIV. But although I'd encountered many patients who were skeptical of HIV medications to varying degrees and for various reasons, none had taken this skepticism as far as Mr. B.

That Saturday, Mr. B. was on my mind. Discovering that his hospice facility happened to be nearby, I decided to visit. When I arrived, his room was quiet except for the tinkling sounds of a water sculpture. Mr. B. looked peaceful and seemed neither especially happy nor annoyed to see me.

"I thought I'd come by and see how you're doing," I said. Then I cut to the chase: "I didn't think you were looking to die. You don't want to be here, do you?"

"I don't," he replied, "but I don't know what can be done for me."

I told him that HIV medications could still work despite his severe illness. He reiterated calmly that HIV doesn't cause AIDS and that HIV medications are useless. I argued that science is an imperfect system but that work is peer reviewed, fake data get exposed, and dozens of rigorous studies with similar results could not all be wrong. His counterarguments contained more than a grain of truth: the pharmaceutical industry influences science, profits dictate medical practice, desire for scientific prestige corrupts researchers. We'd reached a stalemate. "Well," I said, "I don't know if there is anything else I can do for you." The usual departing niceties felt unserviceable. "See you later" seemed false, "Take care" absurd. I finally mumbled "Bye" as I slipped out of the room.

Leaving the hospice, I felt that something remained unsaid, though I didn't know what. Mr. B. was dying. He was not psychotic — he was reasonable. He was not ignorant — he was rather well informed. He didn't want to die but seemed willing to die for his beliefs. I tried to genuinely consider his point of view. How could I be certain that HIV causes AIDS? Had I conducted the experiments myself? Could I even fully understand them?

The truth is that I believe HIV causes AIDS because I trust the people — professors, editors, scientists — who have told me so, not because I can indepen-

dently evaluate and confirm the science. I am part of what anthropologist Heidi Larson calls a "chain of trust" in a social system that has treated me fairly and generously — a chain that did not reach Mr. B. I realized that the chain's links consist of lived experiences and relationships, not data in scientific journals. I believe what my colleagues say because of my proximity to their experience: I work with people like the scientists who conducted the earliest studies, and I know them to be generally honorable and credible. Mr. B. did not believe — ultimately, not because of quibbles with the scientific method, but because the sum of what society, and "expert" professionals like me, had offered him in life seemed more like lies than the truth. Instead of arguing about the veracity of science, perhaps I could simply bear witness, as one human to another. It was worth a shot.

I returned to Mr. B. and began, "I was thinking that you might feel that the world has lied to you many times. I admit that I'm not well versed enough in laboratory science to verify the experiments, but I do know this: I've seen many people who have the same condition you have, and I've given them these medications, and today they are healthy, doing the things they want to in life, even if I cannot be certain exactly why or how. I have seen them for years. I am asking you to trust me on this one."

Mr. B. was silent. I was surprised, and pressing what might be an advantage, I asked, "Would you be willing to try the medications?" I was stunned when he said yes.

I asked a nurse for a spare

dose of antiretroviral medications, which I watched Mr. B. swallow. Now he was on treatment, and I could more easily send him to the emergency department. Over the next few weeks, with inpatient treatment, he recovered remarkably quickly — a phenomenon that was dubbed the “Lazarus effect” early in the HIV-treatment era. Over the subsequent months, he came to my clinic for monitoring. His CD4 levels climbed rapidly. We didn’t discuss the medications, but he’d been discharged with them, and his viral loads were undetectable. When his monthly prescriptions ran low, I renewed them. Over the years, he rarely came to the clinic, yet the pharmacy confirmed he was picking up his medications. In our brief conversations, we focused on how he was feeling: his chronic edema, his weight gain, his housing. We never spoke about that day in the hospice. Years later, I moved and he was assigned to a new clinician.

I’ve been remembering Mr. B. during the Covid pandemic, as

public health and medicine have struggled with public dissent over social distancing, masking, and now vaccination. Covid denialism, like AIDS denialism, reveals that many of doctors’ assumptions are incorrect. We overestimate the value of reasoning and facts. We believe in our clinical authority. We expect patients to behave rationally. But we all develop our beliefs through interactions with other people — what you believe depends on whom you trust. In a life where Mr. B. had struggled, I have been rewarded. He was dying, while I was thriving. No wonder the conventional truths that were self-evident to me would seem otherwise to him.

I never ventured to ask Mr. B. why he’d changed his mind. But if acceptance of Covid vaccines and other evidence-based interventions depends on trust, then doctors have one important card to play. Primary care doctors in particular can know our patients as people, their needs and wants, their preferences and idiosyncrasies, sometimes their fears and hopes. But even hospitalists who

round on a patient for several days form a bond. No disembodied message (even if crafted by marketing experts) can compete with someone you know who will pull up a chair. Even though the pandemic has pushed those in our profession to our emotional and professional limits, one of our oldest tools may turn out to be one of our best: talking with patients. By getting to know patients’ stories, and perhaps letting them know ours, we might be able to add a link to the chain of trust, even if it is a single one, and collectively these conversations may be one potential remedy for the afflicted social fabric of our times.

Disclosure forms provided by the author are available at [NEJM.org](https://www.nejm.org).

From the Division of Infectious Diseases, Department of Medicine, and the Center for Dissemination and Implementation, Institute for Public Health, Washington University, St. Louis.

This article was published on January 1, 2022, at [NEJM.org](https://www.nejm.org).

DOI: [10.1056/NEJMp2115832](https://doi.org/10.1056/NEJMp2115832)

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