The Art of Pimping

IT'S HARD work becoming a revered attending physician in a university hospital. The task daunts the newly appointed junior attending as he strides down the corridor of his first ward with his first team. Oh, he's made some changes in anticipation of his new position. He's wearing a long coat now, an all-cotton coat with razor-sharp creases and knit buttons. The stained, shrunken polyester white pants and tennis shoes have given way to gray, light wool slacks with a cuff and polished loafers. Framed certificates bear testimony to his intelligence and determination. He should be ready to take the helm of his ward team, but he's not. Something's missing, something important, something closer to art than to science. When physicians talk about the "art of medicine" they usually mean healing, or coping with uncertainty, or calculating their federal income taxes. But there's one art this new attending needs to learn before all others: the art of pimping.

Pimping occurs whenever an attending poses a series of very difficult questions to an intern or student. The earliest reference to pimping is attributed to Harvey in London in 1628. He laments his students' lack of enthusiasm for learning the circulation of the blood: "They know nothing of Natural Philosophy, these pin-heads. Drunkards, sloths, their bellies filled with Mead and Ale. O that I might see them pimped!"

In 1889, Koch recorded a series of "Pümpfrage" or "pimp questions" he would later use on his rounds in Heidelberg. Unpublished notes made by Abraham Flexner on his visit to Johns Hopkins in 1916 yield the first American reference: "Rounded with Osler today. Riddles house officers with questions. Like a Gatling gun. Welch says students call it 'pimping.' Delightful."

On the surface, the aim of pimping appears to be Socratic instruction. The deeper motivation, however, is political. Proper pimping inculcates the intern with a profound and abiding respect for his attending physician while ridding the intern of needless self-esteem. Furthermore, after being pimped, he is drained of the desire to ask new questions—questions that his attending may be unable to answer. In the heat of the pimp, the young intern is hammered and wrought into the framework of the ward team. Pimping welds the hierarchy of academics in place, so the edifice of medicine may be erected securely, generation upon generation. Of course, being hammered, wrought, and welded may, at times, be somewhat unpleasant for the intern. Still, he enjoys the attention and comes to equate his initial anguish with the aches and pains an athlete suffers during a period of intense conditioning.

Despite its long history and crucial importance in training, pimping as a medical art has received little attention from the educational establishment. A recent survey reveals that fewer than 1 in 20 attending physicians have had any formal training in pimping. In most American medical schools, pimping is covered haphazardly during the third-year medical clerkship or is relegated to a fourth-year elective. In a 1985 poll, over 95% of program directors admitted that the pimping skills of their trainees were "seriously inadequate." It comes as no surprise, then, that the newly appointed attending must teach himself how to pimp. It is to this most junior of attendings, therefore, that I offer the following brief guide to the art of pimping.

Pimp questions should come in rapid succession and should be essentially unanswerable. They may be grouped into five categories:

1. Arcane points of history. These facts are not taught in medical school and are irrelevant to patient care—perfect for pimping. For example, who performed the first lumbar puncture? Or, how was syphilis named?

2. Teleology and metaphysics. These questions lie outside the realm of conventional scientific inquiry and have traditionally been addressed only by medieval philosophers and the editors of the *National Enquirer*. For instance, why are some organs paired?

3. Exceedingly broad questions. For example, what role do prostaglandins play in homeostasis? Or, what is the differential diagnosis of a fever of unknown origin? Even if the intern begins making good points, after 4 or 5 minutes he can be cut off and criticized for missing points he was about to mention. These questions are ideally posed in the final minutes of rounds while the team is charging down a noisy stairwell.

4. Eponyms. These questions are favored by many old-timers who have assiduously avoided learning any new developments in medicine since the germ theory. For instance, where does one find the semilunar space of Traube? Or, whose name is given to the dancing uvula of aortic regurgitation?

5. Technical points of laboratory research. Even when general medical practice has become a dim and distant memory, the attending physician-investigator still knows the details of his research inside and out. For instance, how active are leukocyte-activated killer cells with or without interleukin 2 against sarcoma in the mouse model? Or, what base sequence does the restriction endonuclease *Eco*RI recognize?

Such pimping should do for the third-year student what the Senate hearings did for Robert Bork. The intern, in contrast, is a seasoned veteran and not so easily rattled. Years of relentless pimping have taught him two defenses: the dodge and the bluff.

Dodging avoids the question, wasting time as well as a valuable pimp question. The two most common forms of dodg-

From the Department of Medicine, University of Pittsburgh (Pa).
Reprint requests to 10404 Presbyterian-University Hospital, DeSoto at O'Hara streets, Pittsburgh, PA 15213 (Dr Brancati).

ing are (1) to answer the question with a question and (2) to answer a different question. For example, the intern is asked to explain the pathophysiology of thrombosis secondary to the lupus anticoagulant. He first recites the clotting cascade, then recalls the details of a lupus case he admitted last month, and closes by asking whether pulse-dose steroids are indicated for lupus nephritis. The experienced attending immediately diagnoses this outpouring as a dodge, grabs the intern by the scruff of the neck, and rubs his nose back in the original pimp.

A bluff, unfortunately, is much more damaging than a dodge. Allowed to stand, a bluff promulgates a lie while undermining the academic hierarchy by suggesting that the intern has nothing more to learn from his attending. Bluffs weaken the very fabric of American medicine, threatening our livelihood and our way of life. Like outlaws in a Clint Eastwood movie, bluffs must be shot on sight—no due process, no Miranda Act, no starry-eyed liberal notions of openness or dialogue—just righteous retribution.

Bluffs fall into three readily discernible categories:

1. Hand waving. These bluffs are stock phrases that refer to hot topics in biomedicine without supplying detail or explanation. For example, "It's a membrane transport phenomenon" or "The effect is mediated by prostaglandins." In many institutions, they may evolve directly from the replies of Grand Rounds speakers to questions from the audience.

2. Feigned erudition. The intern's answer, though without substance, suggests an intimate understanding of the literature and a cautiousness born of experience. "Hmmm . . . to my knowledge, that question has not been examined in a prospective controlled fashion" is a common form. Frequently, the bluff is accompanied by three automatisms: clearing of the throat, rapid fluttering of the eyelids and tongue, and chewing on the temples of the eyeglasses. This triad, when full-blown, will make the intern bear a sudden resemblance to William Buckley and is virtually pathognomonic.

3. Higher authority. The intern attributes his answer to the teaching of a particular superior. When the answer is refuted, the blame of ignorance comes to rest on the higher authority, not on the obedient, accepting intern. The strength of the bluff depends on just whom is quoted. An intern quoting a junior resident about pathophysiology is every bit as cogent as Colonel Qaddafi quoting Ayatollah Khomeini about international law. An intern from an Ivy League medical school quoting the "training" he received on his medical clerkship goes over like Dan Quayle explaining the Bill of Rights at an ACLU convention. The shrewd intern, however, will quote his Chairman of Medicine or at least a division chief, pushing the nontenured attending to the brink of political calamity. Did the chairman actually say *that*? The attending is powerless to refute the statement until he is certain.

Indeed, a good bluff is hard to handle. Sometimes the intern's bluff sounds better to the ward team than the attending's correct answer. Sometimes it sounds better to the attending himself. Ultimately, the cunning intern is best discouraged from bluffing by aversive training. Specifically, each time he bluffs successfully, the attending should counter by inducing Sudden Intern Disgrace (SID). SID is induced in two ways:

1. Question the intern's ability to take a history. This technique depends on the phenomenon of historical drift. That is, a patient's story will reliably undergo a significant change in the 8- or 16-hour interval between admission and attending rounds. The attending need only go to the bedside and ask the same questions the intern did the night before. Now the entire case is seen in a light different than that cast by the intern's assessment. Yesterday's right upper quadrant cramping becomes right-sided pleuritic chest pain. Yesterday's ill-defined midepigastric "burning" becomes crushing substernal heaviness radiating to the arm and jaw. Suddenly, the intern is disgraced. He will never bluff again.

2. Question the intern's compulsiveness. In less rigorous programs, this is easy. Did the intern examine the peripheral blood smear and the urine sediment himself? If the intern does routinely examine body fluids, a more methodical approach is required. In this case, results of the following tests, procedures, and examinations may be requested in rapid succession: Hemoccult slide test, urine electrolytes, bedside cold agglutinins and serum viscosity, slit-lamp examination, Schiøtz' tonometry, Gram's stain of the buffy coat, transtracheal aspiration, anoscopy, rigid sigmoidoscopy, and indirect laryngoscopy. Once the attending discovers a test or examination left unperformed, he asks the intern why this obviously crucial point was neglected. (The tension may be heightened at this point by frequent use of the word "cavalier.") The intern's response will generally revolve around time constraints and priorities in diagnostic evaluation. The attending's rejoinder: did the intern eat, sleep, or void last night? The scrupulous intern at once infers that he has placed his own needs before the needs of his patient. Suddenly, he is disgraced. He will never bluff again.

Clearly, pimping—good pimping—is an art. There are styles, approaches, and a few loose rules to guide the novice, but pimping is learned in practice, not theory. Despite its long and glorious history, pimping is in danger of becoming a lost art. Increased specialization, the rise of the HMO, and DRG-based financing are probably to blame, as they are for most problems. The burgeoning budget deficit, the changing demographic profile of the United States, the Carter Administration, inefficiency at the Pentagon, and intense competition from Japan have each played a role, though less directly. Against this mighty array of historical forces stands the beleaguered junior attending armed only with training, wit, and the determination to pimp. It won't be easy to turn back the clock and restore the art of pimping to its former grandeur. I only hope my guide will help.

Frederick L. Brancati, MD