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Introduction
"Be Nice—Until it is Time Not to be Nice"

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THE ORGANIZATIONAL CULTURE of palliative care can be stratified into three value levels[1]: (1) the "surface level values" which can be easily discerned but hard to understand; (2) beneath the surface level are the "espoused values" which are conscious strategies, goals and philosophies; and (3) finally, the inner "core values" which are the basic underlying assumptions and premises of palliative care.

In a field focused on improving care for patients with serious illnesses, clinicians are often caught between vulnerable patients and families who need compassion, gentleness, and sufficient time to make decisions and a health care system that is often fast paced, unrelenting, and less than optimally responsive to the human needs of dying patients and their families. While a gentle compassionate approach is congruent with the core palliative care value of providing quality care, it is true that this soft approach is ineffective when interfacing with main stream medicine and in effecting changes at a health care system level. Thus, palliative care clinicians may often experience the cognitive dissonance created by the need to switch from being the gentle clinician (core value) providing patient-centered care to the unrelenting activist (espoused value) grappling with the system in an effort to foster social change aimed at advancing care at the end of life.

In her essay,[2] Dr. Ferrell describes her professional journey and highlights a couple of potential strategies that can aid in overcoming the cognitive dissonance generated when a clinician has to frequently oscillate between seemingly incompatible values (morphing from a mild-mannered clinician to radical change agent and back). First, finding a work life balance helps sustain the inner core of energy and serves to reduce work related stresses. Second, it is known that cognitive dissonance[3] can be reduced either by eliminating the dissonant cognitions (this may not be a feasible option as palliative care professionals need to be both gentle clinicians and radical activists), or by adding new consonant cognitions. As palliative care clinicians we are acutely aware and even seek systematic training that will help us communicate skillfully with patients. While compassionate communication strategies and "niceness"[4] may correlate with successful patient interactions, "niceness" is not an effective strategy in dealing with the system. We may need to seek other special business and leadership skills that will enable us to effectively interface with the health care system and foster social change.

REFERENCES

1. Schein E: *Organizational Culture and Leadership*. San Francisco: Jossey-Bass Inc., 1992.
2. Ferrell B: On finding a balance. J Palliat Med 2007;10: 309–312.
3. Festinger L: *A Theory of Cognitive Dissonance*. Stanford, CA: Stanford University Press, 1957.
4. Li S: "Symbiotic niceness": Constructing a therapeutic relationship in psychosocial palliative care. Soc Sci Med 2004;58:2571–2583.

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