Caring for the Patient

I sought for happiness
Happiness I cannot see
I seek for richness of spirit
Richness eluded me
I looked for fulfillment
Fulfillment escaped me
But when I gave Medicine to my brethren
I found all three.

From an unknown source:
Quoted by Singapore physician C. H. Low.¹

The title of this chapter has been shamelessly, yet respectfully, adapted from the title of a lecture given at Harvard Medical School in 1925, one of a series of late-afternoon sessions for medical students, and subsequently published in the Journal of the American Medical Association (JAMA) in 1927. The title of the lecture and the paper was simply “The Care of the Patient.”² Peabody’s lectures and writings were later collected and published in 1931, a project underwritten by his classmates from Harvard Medical School. In the preface to this volume, bacteriologist Hans Zinsser wrote of Peabody’s collected works: “Their publication will serve to continue the influence of a voice that American medicine could ill afford to lose – one of clear-headedness, unsentimental idealism and the great wisdom of affectionate optimism.”³ I mentioned Dr. Peabody’s work to one of our residents, who happens to be a graduate of Harvard Medical School; she replied that while in medical school, she was a member of the Francis Weld Peabody Society.

Peabody’s lecture and subsequent article contain some of the most insightful descriptions of wise clinical practice
Caring for the Patient
ever written. The thoughts expressed are as relevant today as
they were some eight decades ago, and I still give photocopies
of the article to medical students and residents whom I
believe will appreciate the message. The theme of the work is
summed up in the final three sentences: “The good physician
knows his patients through and through, and his knowledge
is bought dearly. Time, sympathy, and understanding must
be lavishly dispensed, but the reward is to be found in that
personal bond which forms the greatest satisfaction of the
practice of medicine. One of the essential qualities of the
clinician is interest in humanity, for the secret of the care of
the patient is in caring for the patient.”

Peabody’s “The Care of the Patient” has been quoted,
reprinted, and photocopied countless times. Even today, it
remains one of medicine’s all-time most influential papers.
The poignant back-story is that at the time of his lectures,
Peabody was aware that he had incurable cancer, which
cailed his early death in 1927 at the age of 46. I refer to
Peabody’s “The Care of the Patient” lecture at this point
because, with great humility, I hope this chapter will reflect
his message to readers.

FIRST, BE A HEALER

The dream of becoming a healer is why most of us became
doctors in the first place. We wanted to take care of sick
people. When I first considered attending medical school
and being a physician, I am sure I was emulating the small
town physicians who had treated my childhood injuries,
removed my tonsils, and made home visits when I was too
sick to get out of bed. In short, when I grew up I wanted to
be a healer – just like them.

The Oxford Handbook of Clinical Medicine has a charming
story, told as only the Brits can do, one that illustrates dif-
ferences between caring for the patient and being a provider
of health care services: A man cut his hand, and went to the
home of his neighbor, a physician. The doctor was out for a
short while, but his 3-year-old daughter asked the neighbor
in, put her clean handkerchief on the laceration, which wasn’t
really very large, and had him sit in daddy’s chair with his
legs raised. “She stroked his head and patted his hand, and told him about her marigolds, and then about her frogs.”

Then, Doctor Daddy returned home. “He quickly turned the neighbor into a patient, and then into a bleeding biohazard, and then dispatched him to Casualty (what we Yanks call the emergency room) for suturing.” At the Casualty, he received “two desultory stitches” and care by a medical student who recommended a tetanus booster, to which – as it turned out – the patient was allergic.

In this narrative, it is reasonable to ask: Who acted as a healer? Was it the physician, who over-reacted to a small cut that he probably could have managed with soap, water, one or two Steri-Strips, and reassurance? Was it the medical student, who placed two (probably unnecessary) sutures, and almost managed to transform a minor injury into an anaphylactic catastrophe? Or was it the 3-year-old girl, who used a clean dressing to help stop bleeding, placed the patient in the appropriate position to prevent syncope, and did her best to distract the injured man?

**BE SURE TO CARE FOR THE PATIENT AS WELL AS THE DISEASE**

British anatomist and politician Auckland Geddes (1879–1954) has observed: “So many come to the sickroom thinking themselves as men of science fighting disease and not as healers with a little knowledge helping nature to get a sick man well.” (Brallier, page 148) Of course, there are moments for the physician to become the rational science-based warrior. Certainly the patient whom my resident and I saw last week with acute abdominal pain expected us to practice scientifically grounded, evidence-based medicine. And yet, when I am the patient, as all of us will be from time to time, I also value highly the clinician who takes the time to listen to my concerns and to explain what’s going on with my body. In his 1925 lecture, Peabody advised, “There are moments, of course, in the cases of serious illness when you think solely of the disease and its treatment; but when the corner is turned and the immediate crisis is passed, you must give your attention to the patient.”
Caring for the patient is not always easy. Our current system of health care encourages disease-oriented thinking. There is National Institutes of Health (NIH) funding for biomedical research on diseases of the eye, heart, lung, blood and so forth, as well as on cancer, mental illness, and pretty much any disease that can muster a large army of advocates. There is, however, no national institute on the care of the patient. I recently received an invitation to attend a conference on how to deal with persons who did not respond to contacts from a diabetic registry, or cholesterol registry, or heart failure registry. The conference description discussed how a patient could be on three or four registries, a situation in which – was I such a patient – I would be annoyed to be so disassembled. Such disease-oriented registries, while valuable in collecting statistics, are not at the core of patient centered care.

And so, most patients are not keenly interested in Greek or Latin names of pathologic entities, disease registries, or silo-based guidelines that ignore all else. Nor are they enthralled by our fascinating hypotheses about disease causality. As Jung stated, “The patient is there to be treated and not to verify a theory.” After the hypothesizing diagnostic possibilities, naming the syndrome, cataloging the patient with others suffering like pathology, consulting the latest evidence, and all the rest of the impersonal acts that occur with disease diagnosis and treatment, the wise physician returns to the very personal business of caring for the patient.

RECOGNIZE THE DIFFERENCE BETWEEN DISEASE AND ILLNESS

Words matter, and physicians, as educated individuals, should strive to use words precisely. Thus, the time has come for me to differentiate between disease and illness. Clinicians sometimes use these words interchangeably, but they have quite different connotations, just as do leadership and management or house and home. The word disease refers to some biologic or mental abnormality such as, for example, lung cancer or schizophrenia. For physicians, a disease name might conjure up an image of the typical clinical presentation, the usual
findings on imaging, the menu of therapeutic options and certain prognostic implications.

**Illness**, on the other hand, includes not only the disease, but also the patient’s experience in regard to the disease, including pain or other type of suffering, its economic impact, and its influence on his or her life and that of the family and close friends. Thus, while disease tends to be somewhat concrete and generally identifiable in a few words, such as heart attack or asthma, illness is more comprehensive, involving the family, community, and the cultural and social context of the person who happens to have the disease. Thus an illness description of a 57-year-old male lung cancer patient might be a life-long smoker who is married, with two children, one of whom has Down syndrome and is dependent on the patient and his wife for care. Aware of the grim prognosis and the anticipated costs of medical treatment, the patient is worried – depressed might be a better descriptor – about not only his future, but also that of his wife and children.

**TRY TO “FEEL” THE PATIENT’S EXPERIENCE OF THE ILLNESS**

McWhinney describes an ideal clinical setting in which “the physician tries to enter the patient’s world, to see the illness through the patient’s eyes.”

Today, such counsel seems self-evident, but seeking synergy with the patient was not always the case. Not too many decades ago, and certainly in Peabody’s time, the prevailing model of medical care could best be described as paternalistic. In a highly imbalanced relationship, the physician prescribed and the patient complied. Think how the term “patient compliance” lingers in our clinical lexicon. The doctor, by virtue of his knowledge and skills, held the power and the patient’s job was simply to follow “doctor’s orders.” Perhaps this explains why Peabody’s ideas were noticed: He described a model of care not in favor at the time. In effect, he advocated that physicians change how they related to patients.

Today, the doctor–patient relationship is more balanced and physicians are encouraged to seek empathic understanding of their patients’ illnesses. In fact, many clinicians do so, or at least they make the attempt.
Why the evolution in clinical practice, the transformation from a paternalistic to a collaborative relationship between patient and doctor? Here, I suggest several key influences: The first was the social upheaval of the 1960s, with the Viet Nam war, the civil rights movement, and a general distrust of experts – which, to some degree, came to include physicians as not-necessarily-trustworthy experts. This era also saw the rise of primary care, promising to reunite a fragmented health care system and return it to the people. Primary care, notably family practice, did not emerge in response to host of new technologic wonders, but as a social movement consistent with the times.

Another paradigm-changing influence was the development of the World Wide Web, opening the libraries of once-arcane medical knowledge to anyone with access to the Internet. The result of the social changes in America, the influence of physicians committed to relationship-based, personal care, and search engines allowing easy access to medical information has been the democratization of health care, with doctors seeking patients’ opinions about their illness and the care decisions being made.

THINK ABOUT THE IMPACT OF ILLNESS ON THE PATIENT

“Feeling” the experience of the illness calls for considering how being sick is upsetting the patient’s world. Part of the clinical skills exhibited by wise physicians is managing both the disease and the mischief the disease is causing in the patient’s life.

When a disease is present, there is always an impact, even if not mentioned by the patient or parent, and regardless of whether or not the physician thinks of them at all. Consider, for example, a patient seen on Wednesday last week. Joey is a 17-year-old boy, brought to the office by his mother because of a severe sore throat, cough, and fever. Now, for a family physician, this is about as routine as it gets. Yet, there is an impact. For example, Joey will miss an important school exam on Thursday, and probably won’t be well enough to play in the school basketball game on Friday evening. Missing the exam may lower his end-of-the-year
class standing just a bit, and missing the basketball game may hurt his chances of getting a needed college scholarship.

The disruption of a minor, self-limited illness pales in comparison to what happens when a person has a chronic, progressive disease. In this setting, I think of Martha, who has chronic obstructive pulmonary disease (COPD), now retired following a two decades of working in a smoky bar-room. Her COPD has led to physical inactivity and compensatory over-eating, bringing her weight to 236 pounds, in turn contributing to her type 2 diabetes mellitus. Thus, at age 58, Martha cannot climb more than one flight of stairs. She cannot go for walks with her two sisters. She isn’t comfortable flying to visit her grandchildren who live across the country. And she can’t visit her old friends in the smoke-filled tavern.

Schillerstrom et al looked at the impact of various medical illnesses on the executive function, which the authors define as “one’s ability to plan, initiate, sequence, monitor, and inhibit goal-directed behaviors.” We all know that the executive function can be adversely affected by dementia, including Alzheimer disease. The authors, however, also found that the executive impairment can occur with a variety of chronic medical diseases, including COPD, diabetes mellitus, and hypertension. In some settings, the executive impairment may be inapparent to the patient and the physician, and is first suspected by the family. Other times, the patient is well aware of cognitive decline.

Here is an example of how executive function impairment may be first suspected by the patient and family who, by limiting social interactions, may both unwittingly contribute to progressive cognitive impairment. When I lived in the small town of New Paltz, New York in the 1960s and 1970s, I was both physician and friend of the boxer Floyd Patterson, one of the finest persons ever to become a sports legend. Floyd was a bright individual who helped scores of young men learn the sport and who championed boxing safety, including the use of thumb-less gloves and headgears.

Sadly I learned later, two decades after I had moved away, that Floyd had, like other aging pugilists such as Joe Lewis, Jerry Quarry, Ingemar Johansson, and Muhammad Ali, suffered
the long-term effects of too many blows to the head. Recently, I read an excellent biography of Patterson, written by Alan Levy. Levy tells how, at a boxing commission meeting in 1998, Patterson could not recall the names of fellow commissioners. “He resigned from the commission the very next day. He knew what was occurring. It had already begun, but he and his friends had kept it quiet...Mrs. Patterson first emphatically denied rumors that her husband often appeared lost and confused.” The author goes on to tell how he went “into relative seclusion” in his rural home in New Paltz, how by 2000, he could not recall his wife’s name and how, “shut away,” he died on May 11, 2006 at age 71. Patterson’s relative seclusion and being shut away (Levy’s words) avoided embarrassment to this proud man, but the paucity of human contact may just have accelerated the mental decline.

CONSIDER HOW THE INDIVIDUAL PATIENT’S ILLNESS AFFECTS THE FAMILY

Let us return to 17-year-old Joey, described above, and his mother. Joey’s mother is a single mom, supporting herself and young son as a receptionist in a local real estate office. In order to drive her son to see the physician today, she lost half a day of work, income she needs to help with the monthly rent. There will be a co-pay for the doctor visit, even though she is lucky enough to have some health insurance. Then, the mother will also have to pay for Joey’s prescription.

When a patient is ill, the rest the family also suffers a disruption of their routine and a threat to their sense of invulnerability. The more serious or the more chronic the illness, the greater the perturbations. Think of the effect of Floyd Patterson’s progressive dementia on his wife and children.

To consider another example, being the parent of a diabetic teenager means that there must be daily vigilance regarding nutrition, frequent visits to the physician, doctor bills related to the disease, and unanticipated trips to the hospital when things go wrong. Occasionally, the patient may seem to use the disease to exert influence in the home and to manipulate other family members. Eventually, siblings may come to resent the diabetic family member, and then they may feel guilty
sometimes, the key to understanding the clinical problem lies in the meaning of the symptom to the patient

Another part of feeling the patient’s experience of the illness is understanding the significance of various disease manifestations to the individual. We sometimes get a hint of the meaning of symptoms when we ask patients what they think might be causing the illness. Sometimes the query is more direct: “What does your pain (or other symptom) mean to you?” The patient with low back pain may be worried about cancer, because that is just how his uncle’s prostate cancer revealed itself not long before he died. A young woman with worsening Crohn disease may be most worried about losing her job. In another setting, the meaning of a clinical manifestation may be the fear of imperiling important relationships, as in the setting of a college student who has just received a diagnosis of genital herpes. A heart failure patient’s chief concern could be that she may not live to see her granddaughter graduate from college next year.

Here is a useful question for a patient with chronic or serious disease: “How would your life be different if you did not have this disease?” Then, be silent and allow the patient to answer.
PART OF CARING FOR THE PATIENT IS “LAYING HANDS” ON THE PATIENT

Here is another lesson I learned from a patient early in my practice years. My patient, Mr. Roma, was an elderly Italian-American, and English was clearly his second language. Every few months, he would come to the office accompanied by his wife, for follow-up of his hypertension and type 2 diabetes mellitus. On the day of my “lesson,” my schedule was especially busy. Fortunately, I thought, Mr. Roma was doing well. His weight was stable. The nurse reported a capillary blood glucose of 86. Excellent! The blood pressure reading, also recorded by the nurse, was 130/82. Great! Mr. and Mrs. Roma and I chatted a little about his diet and his medication, which required no adjustment, and I instructed him to return in 3 months. I was ready to move on to my next patient.

“Wait a minute, Doctor! You haven’t examined me. That is what I pay you for,” he said.

Of course, he was right. I had not visualized his eye grounds, listened to his heart or checked his feet – all good things to do when caring for a diabetic patient. I had examined these areas recently, just not today. This was not good enough for Mr. Roma. He had come for a “check-up,” and that meant an examination.

 Appropriately chastised, I personally repeated his blood pressure determination and performed a screening physical examination. And today, I advise student and residents to perform some sort of physical examination – to “lay hands” on every patient they see, even if it is only taking the blood pressure myself and checking the pulse.

PROCEED CAUTIOUSLY WHEN A PATIENT CRITICIZES HIS OR HER LAST PHYSICIAN

Before long, this same individual might be criticizing you to the next physician – or perhaps to an attorney. The patient’s grievance may be quite legitimate, or may be evidence of a blaming mindset. Always remember that there is another version of the story, one that you may never hear.
DIFFICULT PATIENTS EXIST; SO DO “DIFFICULT DOCTORS”

They appear to whine, they blame, they question everything, and they seldom seem to respond to our best therapy. According to Jackson and Kroenke, up to 15% of patient–physician encounters may be labeled as “difficult” by the physicians involved. Some common predictors are anxiety and depression, multiple somatic complaints, and exceptionally severe symptoms. And other patients just seem determined to resist our most diligent efforts to heal.

In the medical literature, the accepted phrase is “difficult patient,” a label I really don’t like. These persons are generally not “difficult” so much as they have a different worldview than their physicians, but I will use the term here because that is the phrase commonly used today. The difficult patient is irritating and frustrating, and most physicians would not be upset to see these individuals change doctors.

Who might the physician perceive as a “difficult” patient? If you will excuse the psychological jargon in the titles, I will describe some types of difficult patients under headings used in the report of a study by Mas and colleagues.

■ Dependent clinger: This type was the most common difficult patient in the study cited. These patients are often seen as “frequent fliers” in the medical office. They call often and become well known to the staff members, who come to consider them annoying, at best. They also have numerous office visits, many not really necessitated by their illnesses, although dependent clingers tend to have a long and colorful medical problem lists. One feature tends to be common among this group: They offer new symptoms late in the visit, often with their hand on the doorknob. “Oh, doctor, I forgot to tell you about the chest pain I had last night.”

■ Entitled demander: “I’m sick and I need to see the doctor this afternoon, but I can’t leave work until 5 PM.” Or “My car is in the shop for repair, and so can the doctor make a house call?” Or “I don’t care if the doctor is with a patient; I need to speak with her now.” This person’s parents never told him to be sensitive to the needs of others. He – or she – has an illness of some kind, and that confers entitlement to
what he wants when he wants it. An interesting variant of the entitled demander is the VIP or celebrity patient, who requires special attention throughout the course of an illness. Although many such persons are actually humble and respectful of the medical team, the situation itself creates a sense of undeserved advantage.

- **Manipulative help-rejecter**: I once had a patient who had fallen from a ladder while working. He suffered a back injury – a worker’s compensation case. Five years after the injury, he continued to visit my office frequently, requesting physical therapy, muscle relaxants, and a lot of attention. He continued to nurture his pain and his worker’s compensation case, and of course he continued to be totally disabled for work.

- **Self-destructive denier**: Oscar Yates, a 76-year-old widower who lived alone, seemed to enjoy rejecting my best stop-smoking efforts: “Yes, I smoke cigarettes. I know they are bad for me, but smoking is what I enjoy most in life, and I don’t plan to quit.” This sort of attitude can – metaphorically, of course – drive a physician crazy. Alcoholics and drug seekers are other examples of self-destructive deniers. Teen-age risk-takers also fit into this group. As an aside, Oscar eventually stopped smoking, all on his own, explaining that finally he became ready to quit.

- **Somatizer**: The word comes from the Greek soma, meaning body. For these persons, everyday stress seems to affect some part of their bodies, resulting in headaches, fatigue, abdominal pain, backache and so forth. Of course, no amount of explanation relieves the symptoms of the somatizer, who generally lacks insight into the mind–body connection.

- **Emotive seducer**: This patient coaxes the physician into a web of involvement, generally concerning crises in her – or his – life. In my experience, most of the emotive seducers are women. Terrible things happen in their lives, over and over, prompting visits to the physician for comfort and solace. Wise physicians soon learn to be quite wary of the emotive seducer.

If faced with a “difficult patient,” ask first if there is something you just don’t understand yet. Consider that occasionally the
core problem may have a legitimate medical label: For example, quite often patients with borderline personality disorder are dismissed as “difficult patients.” These individuals and others like the patient with multiple interrelated problems may really be “heartsink” patients (See chapter 7), rather than “difficult” patients.

Of course, the patient is only half of the “difficult” patient–physician dyad. The other person in the dysfunctional relationship is the physician. Sad to say, some physicians can be dogmatic, defensive, or arrogant; others are harried and tired. In a revealing study, Krebs et al wondered if there are identifiable traits of physicians who are likely to express frustration with patients, tending to label them as difficult. In a survey of 1,391 physicians, the authors found that physicians tending to express irritation with patients had certain characteristics. These physicians tended to be younger, to work long hours, to have more than their share of patients with psychosocial problems or substance abuse, and to practice in a medical subspecialty. The physicians who felt annoyance with patients also were likely to suffer anxiety, stress, and depression.

Wise physicians do their best to approach the difficult patient encounter with equanimity, and attempt to view such interactions analytically. Think of the interaction in the model proposed by in a qualitative study by Elder et al. “Difficult encounters occurred when these patient behaviors and medical problems clashed with physicians’ personal and practice traits.”

Here is a suggested viewpoint: As a physician, try to feel honored that you have a few “difficult patients.” That they stick with you is a tribute to your ability to exhibit patience and to your personal optimism. And the next time things seem to be exasperating, try this approach: “This visit isn’t going well. Can we start over at the beginning?”

SOME PATIENTS WILL ALSO BE YOUR FRIENDS

I have heard a few medical students remark: “I would never treat a friend.” To this aspiring physician I would say, “Then you should plan never to practice in a small town.” As a family doctor for 14 years in a small town setting, I can’t
say I knew everyone in town, but I think that most people in town knew who I was – The Doctor. What’s more, many of my friends were also my patients. (I must confess that I took some pride in their faith in my abilities.) I treated their sore throats and their fractures, I diagnosed their diabetes and cancers, and I did my best to be there when they needed me. I did not consider it unusual to see a person at a social event Saturday evening and then examine him or her in the office on Monday. That is what small town doctors do.

Occasionally a patient would remark that, in the office setting, I seemed more “formal.” When I was in small-town practice I didn’t wear a white coat, perhaps because I feared it might frighten the children who visited my office. The white coat came later when I became an “academic physician.” The perceived formality, instead, was my persona as a physician. Figuratively, I put on my “doctor hat,” and assumed the physician role.

In his book on *Doctoring*, Eric Cassell writes about the friend as patient: “A patient as a patient is not a friend even if the patient is a friend. A friend who is a patient is a patient while a patient and a friend in other settings. (This may be a difficult distinction to maintain on occasion. When I see my friends who are also patients in personal settings, I literally cannot remember intimate medical details about them.)”

Actually, although I greatly respect Eric Cassell and his work, I must wonder about the parenthetical comments. When I have a patient who is also a friend, and I see the friend at the grocery store or on the street, I really don’t have amnesia for the medical details. In fact, I often pay special attention to the patient-friend in these settings, wondering about behavior that may influence the disease and how the disease might be influencing his or her life at that moment. For example, if treating a patient-friend with a weight or cholesterol problem, I will quietly sneak a glance at the foods in the shopping cart or portions consumed at a dinner. If treating my patient-friend for an injury or back strain, I will watch how he moves his body even if I happen to be observing him outside the office setting.

All of us who have practiced in small towns know that, if you exclude your patients from your circle of friends, you
may be quite lonely. I have always had friends, and even a few physician colleagues as patients. Or, from another perspective, my wife and I have ended up as friends with persons who began as patients. We, as physicians, just need to remember which hat we are wearing when – the friend hat or the doctor hat. It is really not difficult.

**SOME OF YOUR MOST IMPORTANT LESSONS WILL BE LEARNED FROM PATIENTS**

In my very first week of private practice, when I was the new doctor in the small group, I was assigned to take care of emergency patients. One of these was an 11-year-old girl with a laceration on her arm. Clearly, she needed a few sutures. I instructed the nurse to prep the wound and open a suture set while I went to see the next patient. A few minutes later, there was a ruckus in the hall – a hysterical girl and an angry mother. I exited the exam room to be greeted by the mother’s wrath: “Doctor, I know you’re young and new to town. And you have some lessons to learn. Don’t ever set out needles and thread and scissors and then leave the room for a child to stare at and wait for you. I’m not surprised my daughter panicked!” As reader, you may or may not agree with the mother’s stance, but for me it was a lifelong professional lesson: Don’t set out an open suture set for an adolescent to ponder. And, with children, if you describe a procedure that may cause pain, such as an injection, get it done fast.

In medical history, there are numerous examples in which lessons learned from patients have advanced medical science. In the late eighteenth century, English physician and amateur botanist William Withering (1741–1799) learned from a village woman – some say a gypsy – that a tea she brewed from a secret recipe could cure dropsy (heart failure). After convincing the woman to share her recipe with him, Withering concluded that the active ingredient was the foxglove plant. The doctor began to use foxglove tea to treat heart failure patients in his practice, and subsequently described the success of this method in a paper published in 1785 titled “An Account of the Foxglove and Some of Its Medical Uses.” (Taylor, page 15)
A few years later, a physician in the village of Berkley in Gloustershire, England wondered about the boasts of local milkmaids: “I won’t get the smallpox; I’ve had the cowpox.” In 1796, the physician, Edward Jenner (1749–1823), conducted a human experiment by inoculating a local boy with material from a cowpox pustule. Only mild disease developed, and when later Jenner exposed the boy to variolar material, no sickness occurred. Jenner, like Withering, reported his results, thus assuring a place in medical history – thanks to lessons learned from village milkmaids in his practice. (Gordon, page 65)

Although the advance should be attributed to a caregiver rather than to the actual patients – newborn infants – a chance observation led to the phototherapy technique used today to treat elevated and potentially toxic bilirubin levels in newborns. A nursery attendant, Sister J. Ward, noticed that jaundiced babies lost their yellow hue faster when exposed to sunlight, and so she clustered them near the nursery window.17 Today, light therapy is commonly used to treat neonatal hyperbilirubinemia.

In a somewhat similar vein, the observation of mothers of children with cystic fibrosis that their children tasted salty when kissed led to the finding of a high salt content in the sweat of affected children, and eventually to a sweat test used to help diagnose the disease. (Collins, page 112)

On a more humble note, some of my patients have taught me the dignity of the human spirit, accepting with equanimity various types of chronic illness, disability, loss of family members, and even terminal disease.

**DON’T DISMISS LIGHTLY A PATIENT’S RESEARCH ON THE INTERNET AND IN MAGAZINES AND NEWSPAPERS**

For example, over the years, patients have told me about new remedies, which are sometimes discussed in the media before they are announced to the medical world. Years ago, my first knowledge about using antibiotics to treat peptic ulcer disease came from a patient, a stockbroker who had read an early report in the *Wall Street Journal*. Patients have told me about herbal remedies outside my traditional therapeutic
armamentarium, agencies where my other patients can obtain needed social services, and the locations of helpful web sites I would have never found otherwise.

**GIVE THE PATIENT THE BEST DIAGNOSIS POSSIBLE AT THE TIME**

You help the patient in many ways when you give the disease a name. By telling the patient with pelvic pain that she has endometriosis, you are also saying that she does not have ovarian cancer, which might be just what she was worried about. A specific diagnosis, such as Achilles tendinitis or gallstones, gives the patient something to look up on the Internet. Even if the exact nature of the disease is still unclear, it helps to offer a general, descriptive diagnosis, such as “allergic rash,” “probable viral infection,” or “irritation of the stomach lining.” At the end of a visit, there may be a cluster of family members in the waiting room waiting to ask, “What did the doctor say is wrong with you?” A reply from the patient, “The doctor doesn’t really know,” is not a satisfying answer.

Lipkin relates what happened to him on one occasion when he and the patient sought a diagnosis: “There are those who respect the frank statement, ‘I’m not sure what’s wrong but I will try to find out.’ But once, after I had made such a remark, a highly intelligent but anxious woman replied angrily, ‘Don’t tell me you don’t know! When my brother asked my father how many tiles there were on the room of the cathedral, he told him 174,692. My brother was satisfied. I don’t care what you tell me. Just tell me something definite!’” (Lipkin, page 167)

**SOMETIMES IT’S APPROPRIATE TO USE HUMOR IN THE EXAM ROOM**

Sometimes! Describing his personal health problems, Norman Cousins has popularized the therapeutic value of humor. What is the role of humor in the clinical encounter? What is and is not appropriate? When suitable to the context, humor can relieve anxiety and help to humanize the physician.
But what is proper can be a tricky issue, chiefly because of the vulnerability of the patient in any medical setting.

Patients seem to be keenly aware when the physician uses humor. In a study of 250 consecutive encounters in 15 practices, Granek–Catarivas et al found that almost 60 per cent of patients reported that the doctor had used some humor during the visit, while only 38% of these physicians reported using humor. The authors concluded, “Patients seem to be more sensitized to humor than physicians, probably because of their high stress level during medical encounters.”

Probably safest is patient-generated playful humor. During my medical school years, a group of us were examining an elderly lady with a loud murmur. When the blood flow in the heart is disturbed by a faulty valve, there is often turbulence that can be palpated through the chest wall. For historical reasons I have never quite understood, this phenomenon is called a “thrill.” One day, we earnest trainees in our short white coats surrounded the hospital bed and as instructed by our attending physician, one by one, we ceremoniously pressed our examining hands on the lady’s chest. Then, it was the turn of one slightly anxious young male student. As he finished his exam, the instructor asked him, “Did you feel a thrill?” At this point, the patient chimed in, “Sonny, if I were 50 years younger, you would have.” Slightly raunchy, but no harm done, and the until-then passive patient clearly had assumed control of the situation.

Then, there is physician-generated situational humor. In another setting, a physician was doing a rectal and prostate exam on a male patient, who turned his head and remarked, “Doc, I hate this part of the examination.” To this the physician replied, “Yes, and it’s not the highlight of my day either.” This remark is a little risky, but probably okay if it helps relieve the distress of an uncomfortable examination.

Most dangerous are physician-generated attempts at humor that might be interpreted as being at the patient’s expense. An elderly man was undergoing prostate surgery likely to result in loss of any sexual function he might have had. When he asked his surgeon about possible effects of the surgery, the reply began, “Well, to begin, you will have
to stop chasing the young girls.” This seems crass and even somewhat cruel. It was clinical humor gone wrong.

The bottom line is this: Use humor in the clinical setting if it is not at the patient’s expense and if it might brighten the patient’s day a little. Keep in mind the power of the physician’s words to hurt as well as to heal. Before making what seems a hilariously witty remark, the wise physician will reflect for a moment. If the little inner voice questions the appropriateness of the comment, then it is probably best left unsaid.

DURING THE MEDICAL ENCOUNTER, ASK THE PATIENT TO TELL ABOUT SOMETHING NONMEDICAL

How’s your mom? Have you had time for some golf lately? How’s your dog? What did you think of the football game on Saturday? Part of caring for patients is getting to know them as persons. This brings us to chatting.

Chatting is the art of making small talk, something else they never taught us in medical school. Yet, making small talk can have a significant influence on what patients think of us and our services. Gross et al assessed patient satisfaction in 2,315 patient–physician encounters. Two of their findings are pertinent here. First of all, they found that the longer the duration of the visit, the greater the patient’s satisfaction was likely to be. And second, patient satisfaction was enhanced when the physician spent a little time chatting about nonmedical topics. Delving a little into the patient’s life doesn’t take very long, it helps enrich the patient’s life story and, who knows, you may just learn something that will prove clinically useful.

OCCASIONALLY SHARE A LITTLE ABOUT YOURSELF

One facet of nonmedical chatting can be revealing a bit about you to the patient. This can be telling about your recent trip, your grandchildren, or even your personal adventures in patienthood. When advising a flu shot, you might include, “I had mine last week.” If you had successful surgery in the past, why not mention this when recommending surgery to a patient?
The patient who has lost a family member to death might be comforted by hearing something like, “I understand. My father died a few years ago, and it was a very hard time for me.”

Beach et al found that in 1,265 clinical encounters, physician self-disclosure occurred in 15.4 per cent of instances. The authors grouped the disclosures into several categories: The most common disclosure involved reassurance, followed by counseling, rapport building, casual comments, intimate comments (such as “I cried a lot with my divorce, too”), and extended narratives generally unrelated to the patient’s condition.21

**AVOID LETTING THE PATIENT BELIEVE THAT YOU ARE INFALLIBLE**

Sharing personal information with patients has one more benefit – it helps to humanize the “god-like” image of the physician. It is good for patients to feel confidence in their physicians, but the sense of confidence should stop short of omniscience with a hint of deification. A patient considering you to know everything and to be immune to error is dangerous for both of you. When this occurs, the patient ceases to question, and problems may not be mentioned. “After all, the doctor knows what he is doing.” The risk to the doctor is the patient’s disillusionment when things go wrong.

Here, I will wonder in print if the potential to be considered omniscient, omnipotent and infallible doesn’t apply especially to surgeons, and within the surgical realm, to neurosurgeons and cardiothoracic surgeons, in particular. I believe that surgeons tend to have immense confidence in their abilities that lets them do their daily work; it takes a certain bravado to cut into the thorax or skull of another person. And perhaps, from time to time, the surgeon’s self-assurance is unconsciously communicated to patients, possibly resulting in expectations of perfection. That surgical outcomes are sometimes less than perfect, and short of patients’ occasionally inflated expectations, is reflected in the high malpractice liability insurance premiums paid by surgeons and in the occasional huge court award.
**SOMETIMES COMFORT IS ALL YOU HAVE TO OFFER**

“To cure sometimes, to relieve often, to comfort always – this is our work. This is the first and great commandment.” Often attributed to Hippocrates, the first part of the quote is inscribed on the statue of Dr. Edward Livingston Trudeau (1848–1915) commemorating his tuberculosis sanitarium at Saranac Lake, New York. (Strauss, page 410.) Here, I will share a personal insight: In my career I have been both a primary care physician and an administrator – specifically, the chairman of a large medical school department. After a year or so in my administrative role I had what I considered a brilliant revelation, which is: Many of the persons coming to me – their chairman – with job problems didn’t really expect me to fix them. They knew the limits of power of my office. What they wanted me to do was listen. Now, this can be very difficult for us physicians, who are biased toward action, toward identifying the problem, and finding a remedy. But in this work setting, the employee sometimes exhibited greater wisdom – looking for empathic comfort rather than an action-based response.

My next epiphany was that this administrative lesson had relevance in my clinical practice. In many situations, especially when chronic or terminal disease is involved, the patients and families know we can’t offer cure; what they want us to do is to listen and understand. The best physicians do their best to be optimistic, even in the direst situations, and often the physician’s hopefulness is the best medicine available.

**ACCEPT HOW PATIENTS WILL JUDGE YOU**

We have all been judged – evaluated – since the day we entered kindergarten and medical schools have raised evaluation to an art form. Being evaluated does not end upon receiving the MD degree, and perhaps the process becomes even intensified. There are specialty certification examinations, state licensing boards, and more, but here I focus on evaluation by patients. Every patient evaluates the doctor on each visit, and will probably not be shy about sharing conclusions with family and friends. How do patients evaluate their physicians?
Hurst writes, “In the final analysis, patients trust doctors to do the right thing. The right thing, of course, is for doctors to act scientifically when they can, but most patients are willing to leave the science to the physician. The patient’s judgment about the physician is commonly based largely on how the physician handles the patient’s general response to the illness. Patients may even recognize and appreciate the vow their doctors have made to obtain the best possible medical care for them despite the numerous obstacles that are commonly placed in the doctor’s way.”

Wise physicians know that patient judgments include intangibles such as punctuality, willingness to listen, perceived truthfulness, optimistic hopefulness, respect for the patient as a person, and even a willingness to disclose a little about themselves.

BEWARE THE POTENTIAL FOR CARING GONE WRONG

Adler writes about sociophysiology, what happens when persons in a bonded dyadic relationship exhibit a correlation of autonomic activity indicators. When this happens in a caring relationship, there is a reduction in the secretion of stress hormones, shifting the neuroendocrine system toward homeostasis. To me, part of what Adler seems to be describing is what happens when two persons – in our case, patient and physician – begin to think as one, almost as if they shared one nervous system. When this occurs, critical thinking may suffer and clinical judgment can be suspended, a pathologic state endangering the quality of health care received.

One example of pathology in the patient–physician relationship is the disease denial and rationalization syndrome. In this setting, both patient and physician enter into an unspoken pact to ignore the need for action in the clinical setting. Here is what happens: Mrs. Pella, age 66, has been Doctor Resnick’s patient for almost 15 years. She sees him every 2 or 3 months for her various ailments, which include obesity with a body weight a little over 200 pounds, type 2 diabetes and hypertension. Her high blood pressure has never been under good control and at each visit Mrs. Pella and Doctor Resnick have more-or-less the same conversation. The script goes like this:
“Mrs. Pella, your blood pressure today is 164/96. I know that you are taking your diuretic every day, but I think we need to add another medicine to bring down your blood pressure. Also you need to lose weight.”

“Doctor, I understand what you’re saying. I’ve been under some stress, with my son, you know. Let me work on my weight until next time. I am sure I can take off a few pounds, and then let’s see if this lowers my blood pressure.”

“Okay, I’ll see you in 2 months. Be sure to keep taking your diuretic and don’t forget to lose some weight.”

Of course, Mrs. Pella’s weight stays stubbornly at the 200+ level, needed adjustments in antihypertensive medication are not made, and the blood pressure doesn’t budge.

Visit after visit, year after year, Mrs. Pella and Doctor Resnick repeat the same script, almost as if they were actors in a play. Together they are denying the significance of her persistent hypertension and rationalizing the need for additional therapy. Dr. Resnick truly cares about Mrs. Pella and both feel that they have an excellent patient–physician relationship. And, in a patient-satisfaction sense, they do, except that their association has entered a pathologic zone – a caring relationship gone wrong – manifested as the disease denial and rationalization syndrome.

**BE THERE FOR THE PATIENT**

Whatever else the physician does, he or she must show up when needed. When a patient has a broken bone, a stroke, or a severe infection, the patient’s physician – or else a surrogate covering for the personal physician – must be available. In my upstate New York practice, I lived eighteen miles of backcountry road from the hospital where my patients were admitted. One Sunday morning in January, I had a single hospitalized patient, Mrs. Martinez, a very elderly woman I was treating for heart failure. She had made good progress and was medically stable. Overnight there had been a foot of snow. What should I do? Dutifully, I braved the elements, made the trip to the hospital, examined my patient, adjusted the medication just a little, and then drove
home on the snowy roads. When I arrived home I called Mrs. Martinez’s daughter and reported on progress. I still recall her response: “Dr. Taylor, I just knew you would get to the hospital to see mom. We have such faith in you!” Somehow, her words made the winter trip more than worthwhile.

Writing for family doctors, but articulating a message pertinent to all physicians, Phillips and Haynes have provided me with one of my favorite quotations: “You can pretend to know, you can pretend to care, but you cannot pretend to be there.” The authors go on to explain, “It is by being there for patients that family physicians provide the things patients seek: touch, trust, understanding, comfort, and healing.”

WISE WORDS ABOUT CARING FOR THE PATIENT

■ [In the case of] one whom you find who falls ill only on rare occasions, do not change any of his habits in his entire regimen. Medieval Jewish rabbi and physician, Moses Maimonides (1135–1204). (Maimonides, page 51)

   This reminds me a little of baseball players who won’t change their sox as long as they are on a winning streak.

■ A cheerful face is nearly as good for an invalid as healthy weather. American statesman Benjamin Franklin (1706–1790) (Quoted in Strauss, page 375.)

   One of America’s most inspired aphorists, Franklin suffered recurrent disabling attacks of gout, one of which prompted him to demur as lead author of the United States Declaration of Independence, ceding the opportunity to Thomas Jefferson. (Taylor 2008, page 189.) With recurrent gouty pain, Franklin must have highly valued cheerful faces about him.

■ The physician must generalize the disease, and individualize the patient. German physician Christoph Wilhelm Hufeland (1762–1836). (Quoted in Brallier, page 207).

   We should all remember this aphorism when applying consensus-based clinical guidelines to individual patients.
For example, guidelines for prostate cancer screening or breast cancer therapy must always be tempered by the clinical context and the patient’s preferences.

■ In spite of all our advances in medical knowledge, it is still true that it is more important to know what sort of patient has a disease than what sort of disease a patient has. American physician and author James J. Walsh (1865–1942).26

■ A physician is obligated to consider more than a diseased organ, even more than the whole man—he must view the man in his world. Harvey Cushing (1869–1939) (Quoted in Brallier, page 232.)

Cushing presents a good example of the distinction between disease and illness.

■ There are some patients whom we cannot help; there are none whom we cannot harm. Arthur L. Bloomfield (1888–1962). (Quoted in Strauss, page 637).

We physicians should consider this aphorism whenever we write a prescription, especially for a drug with which we are newly acquainted.

■ Empathy is the physician’s only panacea. (Meador, No. 185.)

■ No matter how knowledgeable and skilful the physician, the healing process starts with a smile. (Meador, No. 16)

Why not? A cheerful greeting adds no minutes to the length of the encounter, and it certainly makes the patient feel better.

■ Regardless of advances made, effective treatment will continue to depend on knowing the patient and his environment. (Reveno, page 105)

■ Every patient invites the doctor to combine the role of the priest, the philosopher, the poet, and the scholar. American essayist and editor Anatole Broyard (1920–1990) (From Broyard’s essay “Doctor, talk to me.” In: Reynolds and Stone, page 180)

Such a ponderous job description is one more reason why we, as a society, should encourage the best and the brightest to become our healers.
But of course, without sostradanya (compassion) no man is a doctor. A doctor must give a part of his heart to his patient. This metaphoric saying, quoted by Crawshaw, is attributed to “an elderly Russian physician” who was undoubtedly the type of doctor Francis Weld Peabody would have admired.

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