

A Shot to the Gut

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"HOW DO YOU KEEP YOUR patients so focused? We can't end our clinic sessions on time but you do. They keep wanting to talk. Your patients don't." That was the first time any trainees asked me a question like that, and I've been teaching students or residents since my residency began in



1980. I get agita when I run late in clinic so I, myself, am highly focused, to get to the heart of the matter and not inconvenience the remaining patients I've yet to see.

There is, however, another point of view, which is that one can't be too empathetic if the meeting has to run on time. How nice can one be in 20 minutes, or 15 minutes, if the patient and family have needs? How do you spend any number of minutes when someone is grieving for the loss of their dexterity, their voice, their vocation, their hobbies, their future? I try to be nice to everyone. I love my patients. It is a privilege to have a job like mine. I have also wondered for many years about how to teach students about the patient-doctor relationship. I've thought a lot about how I learned to relate to patients, and how to be a good role model for students. I would like to be liked. I've often wondered if I have, in fact, been a good role model. My evaluations

indicate that trainees have perceived me well, although the students are notoriously easy on grading their mentors, even though the ratings are anonymous.

I thought a bit before I responded to the residents. I noted that I thought my age played a role, that patients had

treated me increasingly as the wise, old professor, as I became increasingly white-haired. Also, my patients knew that I ran on time, which they appreciated, and understood that this required restraint on their part. But I also shared with them disturbing observations that both my patients and my secretaries have shared with me over the years, particularly my secretaries. Patients would tell them, after our first meeting, "He wasn't so bad.... You know he looks very intimidating." Looking intimidating is a very good demeanor to have if you're a boxer, football player or lawyer, but not something you'd choose for your doctor. Some of my patients came to make fun of me for not smiling. "Dr. Smile, they call you," one told me, as she giggled. I think that is part of the intimidating feature. Others, perhaps, came to understand that perhaps my facial features were much like what had happened to their own when they developed Parkinson's disease, the "masked

facial expression." When I teach others how to score the standard Parkinson's disease assessment tool, I tell them that I rate myself as a "1," meaning "borderline, could be normal" on facial expression. I assume that the ones who didn't accommodate to that didn't come back. The others concluded, like Barack Obama said of Hillary Clinton, "she's nice enough." I'd like to be nicer than that, but perhaps I can't, at least not in 20 minutes.

Recently I saw a patient who came with her sister, a new patient. I heard them in the corridor, the healthy one ordering the one with mild autism and parkinsonism, around. The patient's sister was mildly hostile. They had lived together for more than 60 years, and their mother had been my patient with Parkinson's disease many years before. "Do you remember my mother? You took care of her 15 years ago." Unfortunately, I did not, but I've seen so many patients with PD that my forgetting was forgivable. I did ok with the patient and the sister, and at the end, the sister told me, approvingly, that I had "mellowed" a lot since she had come with her mother. I was now, "pretty cool. Back then I could have popped you."

It was a hit to the gut. It was undoubtedly good that I had "mellowed," and that, at least in her eyes, I was now "cool," but the old me obviously had not fared so well. I didn't ask her if she came to more than one visit, or if her

mother also felt the same way. Ever since I came across an admonition one doctor imparted to his son, during his training to also become a doctor, “You can’t always be right, but you can always be nice,” I have tried to live by that maxim, undoubtedly failing often. I realize that one person’s assessment isn’t proof of failure, but I also know that few patients are going to share a negative impression of me or their other doctors. I remain unsure whether she had finally “got back” at me for the way she perceived I had treated her mother, or she was being positive and friendly, congratulating me on becoming more of a “*mensh*.”

I have thought about my patient relationships for a long time. I’m sure

most of my physician and other health professional colleagues do as well. There are certainly some people we don’t interact well with and maybe we don’t try our best with them. Sometimes we’re irritable, or tired, or running late. No one’s perfect. Patients may hate us for telling them things they don’t want to hear, and there is no universal way to deliver unwanted news in a way that will always be perceived as warm and caring. I also don’t know how we are perceived as the illness advances and “the expert’s” adjustments simply can’t keep up. There are many ways in which we fail our patients.

It will take a long time for this hurt to fade. It never did for my patient’s sister. I will try harder to be nice (as I can). ❖

Author

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