

Lessons From Our Learners

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Feature Editor

Editor's Note: Submissions to this column may be in the form of papers, essays, poetry, or other similar forms. Editorial assistance will be provided to develop early concepts or drafts. If you have a potential submission or idea, or if you would like reactions to a document in progress, contact the series editor directly: William D. Grant, EdD, SUNY Upstate Medical University, Department of Family Medicine, 475 Irving Ave., Suite 200, Syracuse, NY 13210. 315-464-4365. Fax: 315-464-6982. grantw@upstate.edu.

Affect and the Art of Healing

Leigh LoPresti, MD; Lawrence Lee, MD

"Hi, Dr LoPresti."

"Welcome back, Lawrence! Like last time, we have to establish your objectives for the rotation."

"Well, I want to get better at history taking, forming a differential diagnosis, and developing an assessment and plan."

(Sigh. Another day, another medical student. The same goals every medical student gives.)

"That's not acceptable. Those were your objectives last time."

"Well, aren't they things I need to work on?" Lawrence replied, obviously wondering where this was going.

"We all need to improve those skills throughout our careers. This is a senior medical student rotation, so I want you to learn more than that. Lawrence, I want you to think outside the 'medical box.'"

"What do you mean?"

"The best description I've heard of a physician's work is this: 'to

cure sometimes, to relieve often, to comfort always.' There will be times when you cannot cure the patient and times when you may only partially relieve their pain or suffering. But there is no excuse for not comforting them! What is comfort for a patient? Perhaps it is a plan for investigation or treatment, perhaps giving them the hope that they will get better. It can be making them smile or laugh. It can be building trust and making them feel that you care about them. These are some of the things that will make them feel better—and feeling better is what they came for!

During my medical school psychiatry rotation, my attending made diagnoses after talking to patients for no more than 5 minutes (we timed him!). And he was nearly always right! He revealed his secret at the end of the rotation, which was simply to think about how he felt as he left the room. For example, if he felt depressed when he left the room, then the patient was depressed, or if the conversation had made little sense, they were psychotic. Of course, he had all the categories, and his diagnoses were more specific within those categories, but you get the point.

The fact that medical diagnoses could be made accurately in such a 'nonscientific' way was earth-shaking to me—so much so that I have never forgotten it. I learned it was acceptable for doctors to feel—and that would help me do my work more effectively."

Lawrence's brow wrinkled for a moment. *"I thought we were supposed to remain objective. How can we be objective and pay attention to how we feel?"*

"Being objective does not mean we are not human as well. To be truly effective, you must be aware of the feelings of patients and/or family members. Let me give you an example: during my residency, I received a panicked call from a patient's wife, asking me to make a house call on Christmas for her husband Dennis, but she couldn't explain why. Not knowing what to do, I called my backup attending regarding this, and his first question was, 'Did she swear at you?' Assured that she had—extensively and creatively—he told me, 'You must go see him.' Dennis was a well-known patient of his, and he knew that Dennis's wife swore only when Dennis was very ill, and she was very stressed. Dennis was ad-

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From the Waukesha Family Medicine Residency Program, Waukesha, Wis (Dr LoPresti); and In His Image Family Medicine Residency Program, Tulsa, Okla (Dr Lee).

mitted to the ICU, and I learned the value of truly knowing my patients and their families.”

Lawrence shook his head, “*If I focus on everyone’s feelings, how do I practice evidence-based medicine?*”

“Lawrence, medical knowledge and research are important; you definitely need to know your stuff! But you can’t treat a patient only as an illness to be treated or a diagnosis to be made. Always remember that they are a person—with feelings! Often, that’s all they want from you. To see things as they patients do. What scares them? What are they most concerned about? That’s what your patients are really asking of you—to care about them, not just their problems.

Lawrence appeared doubtful. “*That makes sense, but I think it would be hard to fit the medical and the affective aspects together.*”

“People talk about the science of medicine and the art of medicine. I disagree. There is the science of medicine, and there is the art of healing.” I read the plaque on my wall aloud, “The secret of patient care is caring for the patient.” “It sounds so simple, but it’s so true! How often do we not acknowledge that our patients have feelings? Do we forget because there is no evidence for treating our patients as people or empathizing with them? Or do we forget because it is easier to treat a disease than it is to heal

a person? When we heal, we treat the whole person.”

Lawrence replied with a story of his own. “*I once held a patient’s hand and comforted her during a central line placement, because she was scared. The attending told me later I should not have held her hand but that I should have been fully focused on the procedure, because that was what she needed, that was what was ‘best for her.’ So, I’ve actually been told to not address feelings...*”

“Patients are often scared! Your patient was undoubtedly told about potential risks associated with the procedure—like pneumothorax—and that’s probably what she focused on. A correctly done informed consent may give information but not address the patient’s needs: she needed caring, and you gave it to her. Bravo! You saw the procedure through the eyes of your patient.

Patients cannot judge your medical competence; instead, they assume it. Listen when people talk about doctors: they don’t ever say ‘smart’ or ‘knowledgeable’; they say ‘nice’ or ‘caring.’”

Lawrence let this soak in before responding, “*Let me get this right. You are saying that patients will assume that I’m competent, so my professional responsibility is to make sure that I am. However, what my patients will actually judge me on is whether they feel cared*

about. You’re saying that I need to understand their feelings, to recognize their fears and address their questions.” He nodded as he finished his thoughts, “*That way, I can truly comfort my patients by meeting them where they are.*”

“The relationship between a doctor and a patient is truly a powerful thing. It is not always going to be pleasant or easy—but doctor-patient relationships are what make a career in medicine worthwhile—and fun. A good family doctor is passionate about both medicine and people. Patients want a doctor who will celebrate with them and grieve with them. They want someone who will be with them and someone who will be with them. So, your objective for this rotation will be to do good medicine and to sense the feelings in the exam room. I will ask you, frequently, ‘How did it feel?’”

“*Wait a minute,*” Lawrence interjected. “*Do you want to know how I feel, or how the patient feels, or how you feel?*”

“All of the above.”

Acknowledgments: Dr LoPresti would like to dedicate this to John Saia, MD, his mentor, who taught him to love his patients and thus love his career.

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