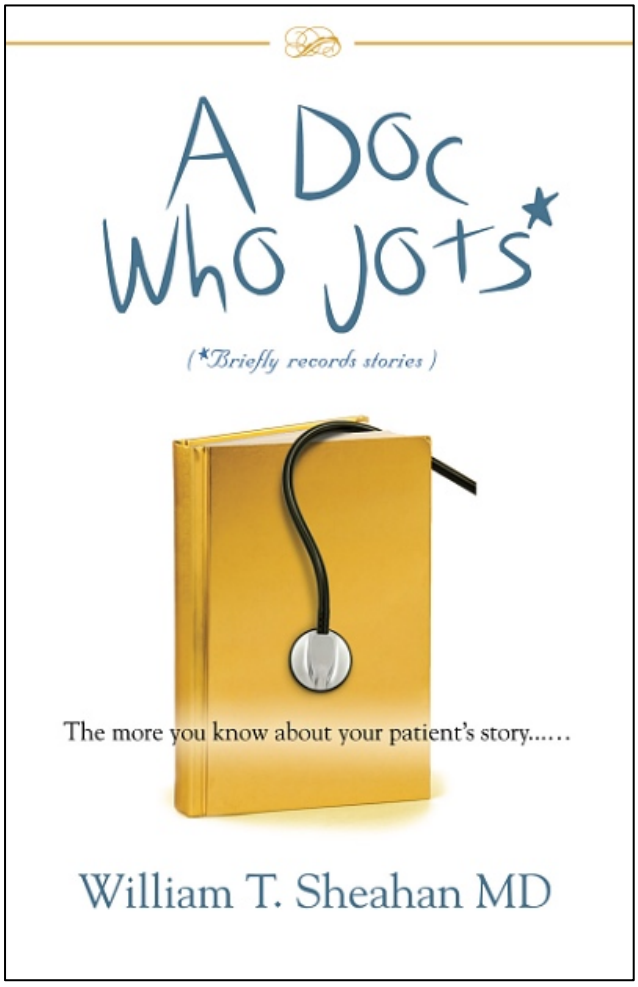

Some will illustrate the ability to tease out some unique, uplifting, or funny aspects that arise during many patient encounters, even during a hectic day.

A Doc Who Jots:
The more you know about your patient's story.....
By William T. Sheahan MD

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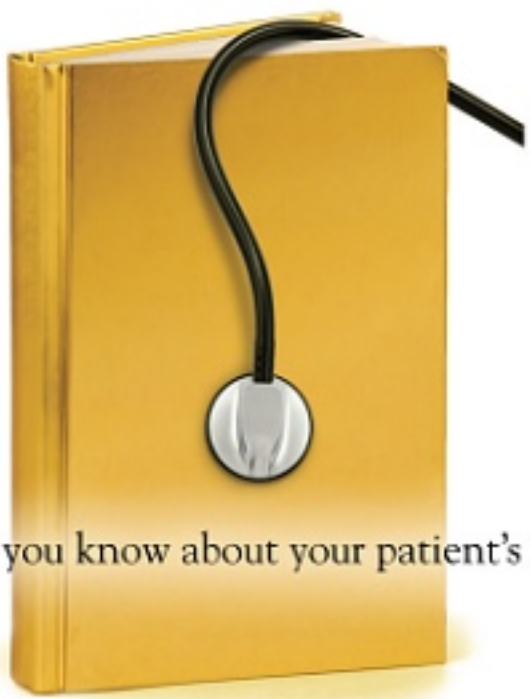
A Doc Who Jots*

*(*Briefly records stories)*



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William T. Sheahan MD

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Disclaimer:

The author is a physician, and this book contains parts of actual patient-physician encounters.

All the names (or initials) of the patients have been changed.

This book is not intended to be a substitute for an appropriate healthcare consultation with your physician or licensed health care practitioner.

Contents

Introduction

Getting to know the whole patient is a core principle of both family medicine and geriatrics—it's especially emphasized during the physician-in-training years.

After medical school I completed a three-year family medicine residency and then a two-year geriatric fellowship.

Once practicing full time, however, my primary focus was to navigate as quickly as possible through encounters, trying to be as productive as the other well-established practitioners in the group.

But envisioning this as my status-quo for years to come, didn't necessarily inspire me to covet a long career in primary care.

I occasionally daydreamed about walking away from medicine for an alternative career even though I had only been out of medical school for about ten years.

However, an article in 1996 by George S. Poehlman MD in *The Journal of Family Practice*, *Dr. Poehlman's pearls*, reminded me of a core principle I had ignored:

"*Always ask your patients about something that is totally nonmedical before closing out the patient encounter. You will ensure that your life's work is made up of more than simply treating disease. You will become an amateur anthropologist on whom people's stories are bestowed. This is what makes men and women of medicine wise*."

It didn't add a significant amount of time to an encounter, and I started to briefly jot down parts of encounters that seemed unique, uplifting, or funny.

Occasionally, after some reflection, I would also tease out something positive from what may have otherwise been a less-than-optimal encounter.

Behavioralist's refer to this as cognitive reframing.

I had a renewed appreciation for my career, and I transitioned home in a much better frame of mind.

The first three books compiled were entitled "*Patients Say the Darndest Things*."

(BookLocker.com: book #1: 2003, book #2: 2006, book #3: 2009.)

This collection has a different title.

Surveys have consistently documented that up to fifty percent or more of medical students, residents, nurses, and doctors experience burn out.

It's usually been taught that it's best to avoid getting too close to patients emotionally to reduce the risk for burn out.

It's logical to think this way for self-preservation and to ensure professional boundaries are maintained.

However, in their book, *Compassionomics*, Drs. Trzeciak and Mazzarelli present evidence-based information that contrasts with this previously accepted dogma:

"*Compassion is not only a powerful therapy for the person receiving compassion, but it is a powerful therapy for the person giving compassion too. That's what the latest science shows. And that's why compassion can be such a powerful treatment for burnout among health care providers*."

"*Of course, it is intuitive to some extent that there could be risk of burnout with repeated or excessive exposure to human suffering. However, the preponderance of data in the scientific literature supports a different view: It shows that human connection can transform the experience for the giver of compassion, trigger positive emotion, and build resilience*."

Health is not necessarily the absence of disease--It's a state of mind that allows a person to remain resilient--to enjoy and appreciate life to the greatest extent possible--despite his or her underlying medical diagnoses or conditions.

It's therefore feasible that resilience can be enhanced in both the provider and the patient through increased human connectiveness.

Pastor Rick Warren has noted that a key to improving most relationships is to "*Don't try to be interesting; be interested*."

Parker Palmer has said, "*The more you know about another person's story, the less possible it is to see that person as your enemy.*"

I've amended his quote to "*The more you know about your patient's story, the less possible it is to see that person as just your patient*."

Sadly, suicide rates for health care workers are significantly higher than the general population, while many health indices are lower.

Fortunately, most healthcare organizations now have dedicated teams to promote wellness. Some even have "chief wellness officers," many of whom are physicians.

There are also independent practices around the country that offer retreats, conferences, consultations, and counseling for health care professionals in need.

It's been shown that there's a direct correlation between wellness and job satisfaction, work attendance, retention, revenues, quality of care and patient satisfaction scores.

Some thoughts on difficult patient encounters.

Clinicians rate a high percentage of encounters with patients as difficult.

It's often not difficult in the sense of having complex medical issues; it's just being difficult, for a multitude of reasons, which includes aberrant behavior.

Recent surveys have concluded that aberrant behavior has, unfortunately, increased during the pandemic.

Most practitioners note a greater degree of disillusionment with their medical career after experiencing numerous such encounters.

An encounter that invokes less than altruistic thoughts is usually consistent with my definition of a difficult encounter.

The late Dr. B. Lewis Barnett, Jr., was a mentor, a friend, and a family medicine icon. In his book, "*Between the Lines (Reflections of a Family Physician)*," Dr. B. noted, "*There are patients who try our souls and who seem to be the devil's very advocate," but then also reminds us that we must "look through the dismal side of them to see their real beauty and worth.*"

Clinicians are more likely to consider encounters as difficult when they are defensive, angry, arrogant, authoritative, sleep deprived, or burnt-out.

My attitude and biases can also play a significant role in less-than-optimal encounters.

Therefore, it's appropriate to self-reflect on my role in either contributing to or exacerbating difficult encounters.

Behavioral experts offer advice through books, articles, conferences, and role play but experience, including many less-than-optimal encounters, has enlightened me as to which strategies seem to work most consistently.

Staying calm, remaining as respectful as possible, and showing empathy, has been my most successful formula.

And, getting difficult patients to also engage about something that is totally nonmedical, if such efforts are possible and not rebuked, may help to foster a more favorable relationship over time.

Negative thoughts on my part may then be considerably attenuated.

Compliance also typically improves—so many chronic conditions become more manageable--often without any other significant interventions.

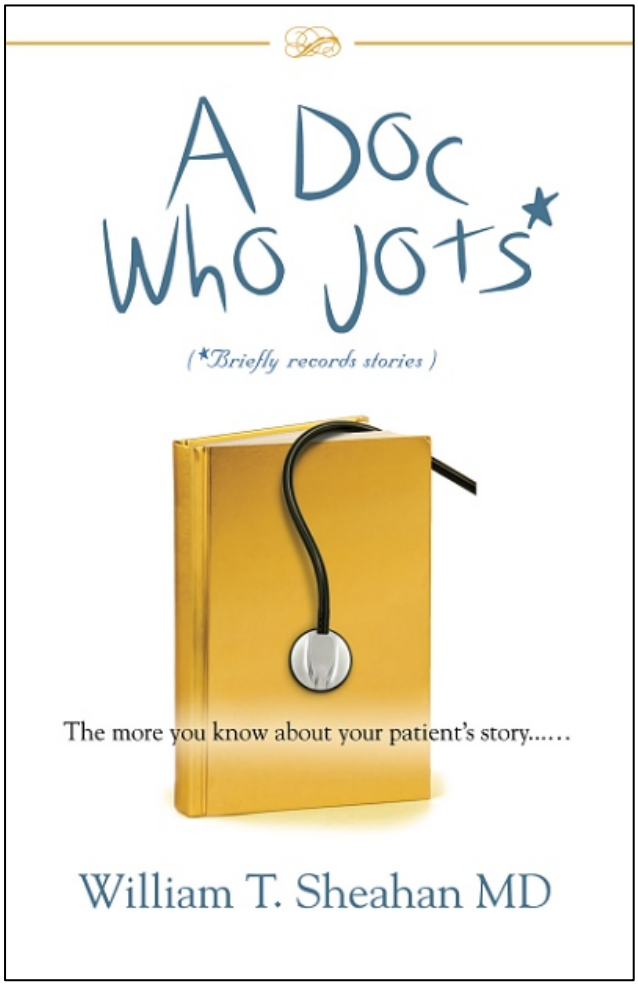
As a result, many days of patient care are much better than they would have been otherwise.

Finally, remember to acknowledge that there's nothing quite like being a patient.

You're fortunate if you haven't been a patient to any significant extent.

I have been several times.

This role reversal is humbling but has always increased my empathy and understanding for the plight of my patients.



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