Bedside Manner

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Patients often discuss the accomplishments of their doctors. A critical qualification always includes the physician's "Bedside Manner." When selecting a doctor, it is usually a deal maker or breaker. Medical schools have more recently implemented training for providing a caring demeanor when attending to patients. Molding a physician's character, however, may take years of experience. The incidents that a doctor responds to can be light or severe, humorous, or life-changing. This blog chronicles some early adventures in the life of this physician as a medical student and practitioner. If these stories spark some interest, provide a comment on a visit, you've had with a physician that revealed an exceptionally good or bad bedside manner. **An individual's or health care facility's name or title is not permissible when commenting.**

Monday, June 16, 2014

Lucy in the Sky without Diamonds

Having completed my medical residency training in the 1960s, a tumultuous period in America, "Make Love, not War" was the mantra that permeated the culture of the "Flower Children." Like the beat generation before them, they desperately tried to break away from the conservative practices that this country sanctioned. I had minimal exposure to the Flower Children's period since I chose to study medicine. I appreciated the exceptional music of that era from Bob Dylan, The Beatles, Jim Hendrix, and others that captured the ethos of that period. At that time, I remember attending a medical meeting in San Francisco near a park occupied by the Flower Children. They were a colorful group dressed in different outfits with a mix of loud and dazzling colors. Assembled in a disorganized and non-intrusive manner, making no loud noises or booming music and generally no hoopla, they appeared peaceful and non-threatening. They seemed to be a generation that preferred to demonstrate their independence in colorful clothing, hairstyles of different colors, music, and drugs. They were devotees of drugs that produced psychedelic effects and hallucinations, which transported them away from the chaos created by their elders. This story is about one of their favorite drugs, LSD, lysergic acid diethylamide. Unlike heroin of the prior generation that dulled the senses, it produced a heightened feeling of being alive with the ability to communicate with an imaginary world of visions, almost spiritual at times. The standard anti-anxiety drug used by the population also evolved in this country from housewives on Miltown in the 1950s, followed by Librium in the 1960s, then Valium

and the current flavor of the decade, Xanax. The Flower Children were not alone as disciples of psychotropic drugs.

While on medical rounds with my intern, Jim, I learned that one of the patients admitted the previous evening to my medical service was a medical student. Rumor had it that he had achieved the highest or one of the highest scores on the MCAT (medical college admission test). He had graduated from Harvard and was a follower of Timothy Leary, the infamous proponent of LSD. This wondrous drug was claimed to have many beneficial psychological effects. Our patient was admitted that evening with the diagnosis of labyrinthitis, an imbalance of the middle ear causing dizziness or vertigo. Neither Jim nor I admitted him to the unit since were not on duty that night. The new patient was in the first bed on a large open ward of male patients on the seventh floor of the hospital. The location of the bed was close to the nurse's station so they could keep an eye on him. Jim had examined him earlier that morning before rounds, and he was puzzled by the diagnosis. Admitting a patient with that diagnosis to a hospital, especially a city hospital handling life-threatening illness, was unusual. More commonly, the emergency room discharged a patient home with this diagnosis with a handful of seasickness tablets. The other thing confounding Jim was that his physical examination was normal. No physical signs suggested the diagnosis of a middle ear imbalance. Jim also remarked that his patient who I will call Jack for this story presented with a strange affect. He did not speak or answer questions and was restrained in bed with an apparatus that allowed the movement of his arms and legs. Restraints should not have been necessary for this diagnosis unless the patient was confused, which is not usual with just a middle ear imbalance. The constraints allowed some movement while keeping the patient in bed. We assumed they were needed to prevent a confused and dizzy medical student from falling out of bed. After all, it was for the patient's protection, and God help the resident who doesn't appreciate the need for preventing such accidents, especially when caring for a medical student. With new patients, I usually examined them after completing rounds to allow more time for taking a history and performing a physical examination.

Jim and I were examining the fourth or fifth patient on the ward when we heard a commotion with a loud noise coming from the first bed. Jack had taken off his restraints, jumped over the bed rails, and headed to the nearest stairwell. I told Jim to take the fastest route to the ground floor and block Jack's exit from the hospital. Jim, as I recall, was a muscular fellow with a physique resembling that of a football tackle. Our patient was a tall, gaunt guy who did not appear menacing. I followed my patient, who had had a head start. In the stairway, I could see him on the fourth-floor landing looking down at Jim, who amazingly had reached the ground floor. I yelled at Jack to return to bed and reassured him that we would not harm him. There was no answer as he had moved out of sight. All I could hear were clanking noises like metal pots banging together coming from empty green oxygen tanks stored on the stairwell landing. It soon became apparent that Jack was dragging an empty tank along the railing. At the time, the metal tanks were about 4 to 5 feet in height and heavy even

when empty. Jack was attempting to lift the green tank and hurl it down the stairwell at Jim. I yelled to Jim to get away from the stairway and call security.

Security did rescue Jack and placed him in a locked psychiatric ward on the hospital grounds. The following day, a psychiatric hospital in the city, not affiliated with our hospital or medical school accepted him as a patient. I heard that the other hospital had discharged him three days later. I wasn't expecting to hear more about Jack. However, on the fourth or fifth day following his release, I walked in the ward and found the staff huddled together, looking at something on an empty bed. As I approached, I asked what was happening, and they held up a newspaper. The headline on the first page of the paper read LSD killer in large bold print. Jack, after his discharge from the other hospital, returned home, and killed his mother in law. From what I recall, it was a gruesome murder in which he stabbed her more than one hundred times. Not exactly a rational way to handle a troublesome mother in law.

Following the murder, the buzz in the news was that he had a history of taking LSD and continued using it up to the day of his hospitalization. It was all a bad trip (a term that was used to describe the opposite of a high) that made him murder his mother in law. Another theory was that he had experienced an acid flashback, which is a sudden, unanticipated event that can be terrifying. This "Flower Child" drug could make you do terrible things and not just make love. For several months, various theories were bandied about by a generally uninformed public. The final verdict was a very smart paranoid schizophrenic could get high grades on tests while high from drugs. However, a twisted psyche prevented him from becoming a doctor.

Unfortunately, there were no tests at the time to screen for severe psychiatric disorders in medical school applicants. Passing the MCAT test provides essential information about one's intellect but nothing about their personality. The problem is that there is no simple window into a person's psyche or soul to enable us to determine the mental stability required to become a doctor. That said, how can we predict a physician's bedside manner?

Monday, April 15, 2013

PLEASE DON'T SHOOT THE INTERN

After graduating from medical school, I chose to complete my medical training in a city hospital. I thought it would give me the best opportunity to see a wide variety of patients and the freedom to learn medicine without just tagging along with private practitioners. Most of them afraid to allow interns or residents to care for their patients. Obtaining training in a city hospital wasn't a free for all, but it did provide more freedom to get hands-on experience compared to merely learning by following a mentor. One of my most memorable experiences was rotating in the emergency room. The emergency department was enormous and divided into several different regions for surgical cases,

acute medical patients, female and male walk-in or stretcher cases, and an obstetrics section.

One evening I happened to be assigned to the male medical section. As usual, it was full of the sick, the not so ill and those with imagined illness. There was minimal selection of patients by severity of disease at the admitting desk staffed by a receptionist, and orderly who was busy transporting patients. My dull gray room was crowded that night with patients seated on uncomfortable metal chairs lined up against the far wall. The examining area consisted of a stretcher, sink, and desk against the opposite wall, separated from the waiting patients by only by a drawn curtain. As a patient was called to be examined, he gave up his seat to the guy in the adjacent chair and so forth with everyone moving over one position to make room for the next client. It was a musical chair type of operation without the music.

After examining a patient, I'd draw the curtain open and look around the room before calling for the next victim. I noticed an elderly gentleman who by comparison appeared relatively well dressed, with a shirt, a tie, and clean, pressed pants. He was seated at least 10 chairs away from the launching chair and sat there quietly with his eyeglasses fogged up and forehead covered in beads of sweat. I walked over and without saying a word, placed my hand on his forehead. He was burning with fever, and I helped to walk to the examining area. I asked him to undress and pulled the curtain shut. While questioning him about his illness, the curtain was yanked open, and a not so well dressed man entered demanding an examination first.

I explained that the sick old guy had looked like he was ready to pass out and required my attention ahead of all the other patients. The not so well dressed man said he was there before the older man and I would have to exam him first. I told him to wait until I finished with the current patient, and I would then be happy to see him. At that point he put his hand in his pocket and withdrew a small revolver, pointing it at me. My life didn't pass in front of me, but it seems like an eternity before I could respond. He coldly stated that he would kill me if I didn't do what he said. In my initial panicked state, I thought about all the time and effort that had been wasted studying for my brief medical career, which would soon be over. Gathering all the courage I could muster, I coolly told him that killing me would prevent his examination and not make him better. Staring at me, while perspiring with an anguished expression, he said that there were people in the room who were threatening his life. His visions advised him that I had to examine him before they killed him. Well, it was clear that I was dealing with a psychiatric patient. After some thought, he reconsidered his options, and suspiciously handed me the revolver, after pleading with him.

I instructed him to wait on the other side of the room and quickly drew the curtain. With trembling hands, reaching for the phone on the desk, I quietly called security for help. During the episode, the patient sitting on the stretcher sat there peaceful and unruffled with a frozen expression on his face. I shrugged my shoulders and figured he hadn't passed out because of a surge of adrenaline experienced from observing the whole event. I then described the intruder to security so they could identify him and take him to the psychiatric unit. I handed the gun over to them, finished administering to the patient with the fever, and called for the next patient.

Happily, I haven't had any more experiences like that.

Friday, April 5, 2013

BUG CURES STROKE

As a 3rd or 4th year medical student in Washington, DC, I had a clerkship at the Veterans Hospital. A private girls school that had been built in 1930 was converted to a Veterans Hospital after World War Two and existed as such when I was in medical school in the 1960s. The patient rooms had been the dormitory rooms to which very little had been added. The rooms were not air-conditioned, and in the summer, they were hot and sticky. One evening on a sweltering summer night, I was assigned a newly admitted patient to work up. It was a Friday night when many of the weekday patients had been discharged home, and there were hospital beds that were available. Weekends were the time when more homeless veterans appeared in the emergency room, recovering from a week-long lack of adequate nutrition and the over consumption of cheap alcohol.

My patient was admitted with a preliminary diagnosis of stroke. He was a middle-aged male who was unresponsive to verbal stimuli and appeared unable to give a history of his illness. He lay in the bed with his eyes closed, breathing comfortably with stable vital signs. On examination, his limbs were flaccid falling to his side when examined, but responding normally on checking their reflexes with a reflex hammer. While standing next to his bed with my back to an opened window, I heard a strange fluttering sound coming from behind me. A large brown roach about the size of a baseball landed on his bare abdomen. He immediately opened his eyes wide, arched his back upward off of the bed appearing to levitate as he rose upwards and jumped out of bed to run out the room. I ran after him shouting for him to stop so I could finish my examination, but he escaped down a stairwell, and I lost him. To my dismay, I had to report that the exam was incomplete because it was interrupted by a roach that seemed to cure the patient's stroke, and I I lost my patient. The intern informed me later that security had found him, and I could finish my examination. There was no stroke, but irregardless of that, the hospital staff kept him over the weekend. Admitting the homeless on the weekend kept them off of the streets, nourished, washed and dried out (detoxed). It was also a way to keep medical students on their toes.

I doubt that there are any therapeutic roaches curing strokes these days in our modern VA system.

Thursday, February 21, 2013

DOCTOR IVAN THE GREAT

As a medical student, I was assigned to an intern, Ivan, in the University Hospital medical ward and followed him around from patient to patient observing his enthusiasm for taking care of patients. His commitment to evaluating each new patient was so palpable that the patients had the feeling that they were getting the best attention that was possible. Some of the doctors, including his fellow interns and residents, considered his eagerness as one-upmanship, but the patients loved him. Because of his bedside manner, I thought he was phenomenal doctor and call him Ivan the Great, as did the patients.

One particular patient stands out as illustrating some of the conflicts that occur when an intern matches his wits with a senior staff physician. An elderly female patient was admitted who was known as a Grand Matron of High Society. She was celebrated for

raising enormous amounts of money for her favorite religious charity. She was often featured in local newspaper articles on the gala events that she sponsored. Her private physician was primarily known for his practice that catered to the social set and was a priggish fellow with a definite overbearing manner. Ivan was the admitting intern that day who evaluated his patient. I've forgotten the name of the attending physician, but for the sake of the story, I'll call him the Prince. He was in many ways, the complete opposite of Ivan but both had comparable huge egos. The patient had been experiencing difficulty walking and had fallen several times. Because of her advanced age, it was thought that she was experiencing multiple small strokes due to hardening of the arteries in the brain. Ivan did his usual thorough evaluation and entered his findings in the hospital chart along with a concise differential diagnosis listing three different possible diseases or disorders. He ordered the laboratory work and some X-ray examinations that evening.

The Prince came in during the evening to check on his patient and review her hospital chart. He quickly excused himself from the patient's room and ran to the doctor's conference room, searching for Ivan. Ivan was not on call that night and wasn't in the hospital. He became ballistic, ripping out Ivan's history and physical report from the chart and got on the phone and found the medical director in his office. With Ivan's report in his hand, he rushed into the director's office to show him what Ivan had written. The director carefully read the two-page report and asked the Prince what the problem was. The physician was all flustered and stammered demanding, "Do you see what the first diagnosis is!" The director's answer was yes, and added that Ivan's examination was consistent with the diagnosis. The physician in a very imperious tone exclaimed that it was impossible since the patient was a pillar of her church and a spinster who had never married. The diagnosis which hadn't been confirmed as of yet by any tests would ruin her if it became known he shouted. The director telephoned Ivan and told him to come in and rewrite his examination and list his first diagnosis as the last one in his differential list of probable diseases. He warned Ivan that when a sensitive diagnosis was suspected, the admitting physician had to be called first rather than surprising him with your report the next morning on hospital rounds.

The next morning everyone was waiting for the fireworks to start as rounds began as Ivan and the Prince came in to examine the patient. Ivan had stopped by the lab to obtain results of blood work that had been drawn the night before. The confrontation of the two began with a brawl in the hallway that could be seen by the patients. Both were quickly escorted to the conference room to avoid the battle overflowing to the patient's rooms. The Prince told Ivan that his insensitive diagnosis of a dreaded social disease was inappropriate for this sweet old lady whose sole problem consisted of trouble walking. He added that only an arrogant moron who enjoyed grandstanding would come up with that diagnosis before all the tests were evaluated. At that point, Ivan quietly withdrew the lab reports from his pocket and showed him the positive screening test for syphilis. The Prince stated the test was wrong, a false-positive. For him, it was unbelievable that this elderly religious patient had an advanced stage of syphilis; neurosyphilis. Follow up tests confirmed the diagnosis, and a further history revealed that in her youth, she had been sexually active. Neurosyphilis usually develops decades after the initial exposure and can result from a failure to diagnose syphilis at an early stage or from receiving inadequate treatment during its early stages.

I often think about Ivan and wonder what kind of physician he became. He had the temperament of a surgeon but would have been a brilliant internist. Had he maintained the skills he developed when dealing with patients and his incredible bedside manner?

Thursday, February 14, 2013

DOCTOR IVAN THE TERRIBLE

One of my first clinical tours of duty as a medical student was on the Internal Medicine ward at the University Hospital. I was nervous about displaying my ignorance of clinical medicine before the icons of medicine, the full-time academic staff. I was assigned to an intern whose name was Ivan. He was a tall fellow with chiseled facial features and thick black eyebrows that gave him a menacing appearance. His greenish-brown eyes, however, suggested a gentler and mellower person. I was impressed by the energetic and confident way he examined patients and how focused his diagnoses were. Whereas most of the interns would write a laundry list of diagnoses after examining a patient, Ivan would limit his differential diagnosis to two to four disorders at best. They would be listed by their likelihood with the most likely first. Because of his ability to give patients a thorough examination and produce relevant diagnoses, the private physicians frequently requested him rather than the other interns to work up their newly admitted patients. As a rule, the interns were chosen on a rotating basis and not selected individually. He was also the intern who produced the most autopsy cases making him the pride of the director of medicine. Autopsies were very important in academic teaching programs at that time since the number of autopsies were listed in directories that evaluated and described them for prospective interns and residents. The school with the most autopsies usually attracted the best and brightest interns and residents since it provided the best teaching experience. It may seem counter-intuitive that the higher the number of autopsies, the better the medical program but the number of autopsies only reflected the number of deaths in which autopsies were obtained. Those with fewer deaths could have performed more autopsies than one with more deaths. The autopsy, also known as the postmortem examination, is the gold standard for determining the patient's underlying disease, the effect of any treatment, and the cause of death. It is vital for confirming that the diagnosis and treatment were correct and why the patient died. Each week the interns and residents were required to attend the mortality conference where the autopsied cases were reviewed and discussed. CT, MRI, and PET scans weren't invented or used for this purpose until much later. Today the autopsy continues to remain the most objective way to obtain this critical information.

I was Ivan's gofer and followed him around like a groupie followed his rock star, hoping that some of his light would shine on me. One day after arriving on the ward, I found him in an empty patient's room pacing back and forth and mumbling to himself. The patient's bed had been made, but there was no patient in the room since he had died during the night. I thought Ivan was upset about the patient's death, and I went over to console him. I told him that after all, there was nothing that could be done to save the patient. The patient was terminal and expected to die. He looked at me as though I was crazy. He said he wasn't grieving the death but was upset that the family had refused to consent to the autopsy. He tried every maneuver to persuade them except one. I asked him which one hadn't he used, and he didn't answer. I asked him again without a response, and finally, after several more attempts, he replied. He said he could only tell me if I agreed to keep it a secret and not tell anyone else about his method. Without a thought about what I agreed to, I gave him my word. He told me

that he would explain to the families of the deceased that the patient's surgery as a last resort required gold implanted into the body to save the patient's life. He explained there was another route for inserting the gold in patients who hadn't had surgery, but I'll spare you the unpleasant details. I couldn't believe as he continued to tell me, if the gold wasn't removed with an autopsy, the family had to pay for the gold. Dumbstruck, I was speechless. Now it was apparent why the other interns called him Ivan the Terrible. I had naively thought the other interns were just jealous of his success at obtaining an autopsy.

A few years later, when I was an intern, I had a similar problem trying to persuade a family to consent for an autopsy on someone who had died. The patient had had a complicated hospital course, and I really wasn't sure why he died. The family adamantly refused on religious grounds. I tried to explain that the results from the autopsy would help us understand more about the disease and could help other people with the same problem. I thought about Ivan and his crazy method but didn't have the nerve to use it. I clearly remember the second meeting that day with the family accompanied by an elderly rabbi. During a bitterly cold winter snowstorm in the dark and shabby lobby of a city hospital, the family told me emphatically that their rabbi had agreed with them, not to sign the consent. The apprehension I felt that night was only tempered by the strength of their religious conviction requiring an old rabbi shivering from the cold winter evening to persuade me. Obtaining consent for an autopsy has never been easy, but none has been as memorable or challenging.

Wednesday, February 6, 2013

Medicine in Black and White with Shades of Grey

While in medical school, I sat next to a student named Frank during histology class. He became one of my closest friends. Histology is the study of the microscopic appearance of healthy human tissues. Each student had a microscope and a histology text with color illustrations of the tissue sections that he or she used as a referenced to identify the slides under the microscopic. One day the professor was explaining in great detail, a description of microscopic cells on a page from the text that had softer color tones than those appearing on the slide viewed with the microscope. Frank leaned to me and asked me to point out the color that was being described. I thought this was strange since it was fairly obvious from the picture in the book. I looked at the slide in his microscope to see if he was comparing the correct slide to the one described in the book. Everything looked correct, and I asked him what his problem was. He told me in a hushed voice that he was color blind and had to learn the different colors in shades of grey. As a 2nd year medical student without clinical experience, I didn't give it a second thought and was totally oblivious of potential problems, if any, for a color-blind doctor.

Many years went by, and I had lost contact with Frank while we completed our internships, residencies, and military service in different locations. While I was in practice in Florida, I learned he was practicing in Los Angeles, and we resumed our friendship. I then discovered he had become an up and coming plastic surgeon who catered to a Hollywood clientele. I was flabbergasted. When I had the opportunity to see him in person during a car trip to LA with my wife and kids, I questioned him about his color blindness. Specifically, how he was able to perform surgery without being

able to see the color of tissues he operated on, like the arteries, veins, and nerves. He calmly told me it was no different than driving a car and being able to tell a red from a green or yellow traffic light. He became a very successful plastic surgeon despite his color blindness and was a great surgeon and friend.

I guess the lesson I learned was that we need to look beyond color to be successful in life and what others consider impediments can be overcome successfully. I received an email that quotes a Ben Herbster, which sums it up better than I can. He stated, "The greatest waste in the world is the difference between what we are and what we could become."

Thursday, January 24, 2013

Human Anatomy Lab

Nothing experienced in college lab courses could ever prepare you for human anatomy lab in medical school during the 1960s. Sometime during the first few weeks of medical school in Washington DC on a hot sticky September day, the first-year medical students received an introduction to the anatomy lab. Without any forewarning, we entered a large room with 20 or so metal tables with human cadavers covered with sheets. The lab wasn't air-conditioned, but the large windows that extended to the ceiling were numerous and opened. The stench of formaldehyde was overwhelming, hurt your eyes, and induced nausea. Many of the students rushed to the windows to hang their heads out for fresh air, and many vomited out the window. The class was divided into teams of 5 or 6 students for each cadaver. Since there were about 10 women in the class, they got their own tables with female corpses. Don't forget, this is the 1960s we're talking about. The instuctor was a short, stocky man with a thick German accent and thick eyeglass lenses that made his eyes look like they were popping out of his head. He looked like the German prison camp commandant in the movie Stalag 17 or the TV series Hogans Heroes. When he approached you, you weren't sure whether to click your heels and salute or greet him the usual way. Cadaver dissection wasn't pleasant, but we adapted and soon developed ways to lighten things up, with meaningless gags and practical jokes. Every anatomic region you dissected had labels that you pinned to structures so the instructor would know you had identified the anatomy correctly. Usually, the instructor randomly without warning, chose a cadaver to examine. Most of the labels had been placed the day before, and many mornings you would find that someone had switched some of them, moving them around inappropriately. It wasn't unusual to see a label for an eyeball in an armpit. It was all taken in stride and laughed about.

One memorable occasion involved a cadaver table of the female students. Generally, the students arrived in the lab and removed the formaldehyde soaked sheet from the cadaver and inspected their previous day's work. This particular morning shortly after arriving in the lab, there was a sudden loud scream coming from one of the female students' tables. As the other women gathered around the table, there was the roar of laughter and giggling coming from all the female students. Otto, our instructor, ran over to the table to see what was happening and suddenly turned beet red. He began jumping, waving his arms over his head, trying to calm the ruckus to get the attention of the rest of the class. I thought I had heard him yelling ACHTUNG, ACHTUNG but I

was later corrected. He was yelling " attention" in English, but I couldn't understand his thick accent, especially imagining him as the German commandant. One of the taller gals at the table grabbed the unexpected object that was placed in the crotch of the female cadaver and raised it over her head, waving it back and forth. Looking at the greatest practical joker in the class, she yelled out, "Freddy, I think you forgot to take your penis when you left last night." The class erupted in laughter, and Otto could not take command and admonish us for acting so poorly.
I'm sure the next day we got an ear full from the anatomy professor, but I probably was asleep in class and don't remember. I usually fell asleep during the boring anatomy lectures. The story is true, but the names have been changed to protect the innocent and not so innocent.

For all those with a bedside manner out there, please feel free to entertain me (?us) with your surprising stories from the healing professions that may have improved or diminished your bedside manner.