

More than “Just the facts, ma’am”

Steven P. Ringel, MD

Correspondence to
Dr. Ringel:
steven.ringel@ucdenver.edu

Mark Peters waved me over to join him in the corner of our teaching room. Knowing that I spend a good deal of time working on how residents are trained, he wanted me to join a conversation he was having with Hadley, one of our outstanding residents. They were discussing the best method for talking effectively with their patients. Hadley is at the end of her first year as a neurology resident and has been working with Mark for several weeks in the neuromuscular clinic. When I worked with her, I found her to be bright and inquisitive medically, while her interpersonal and communication skills with patients seemed underdeveloped.

Mark asked me to sit in and said, “I’m still looking for ways to convince doctors that to help people we need to understand a lot more about a patient than the dimensions of his or her disease. Hadley and I have been analyzing a difficult conversation we just had with a patient and his wife.”

Mark and I have a shared concern that with so many competing demands on their time, trainees rarely use the opportunity or have the wherewithal to explore the psychosocial and educational background of patients. Many residents believe their job is done if they establish a correct diagnosis and begin treatment. To be fair, few academicians effectively guide residents on how to approach patients whose needs are as much psychological as physical. Even when we do, we cannot provide a standard approach for the resident to rely on because patients are so different and require individualized explanations. How do we teach this avenue of inquiry to residents who are harried and undoubtedly would prefer to be off duty? Can we ignore this responsibility and hope they acquire this skill through trial and error after their training as we did? Both of us certainly could name colleagues who seem never to have acquired this talent. Had they received better instruction, would they communicate more effectively with their patients today?

“Dr. Peters asked me to watch him interview and examine the patient. We’ve been talking about what I observed during his interview. I understand better now why he wanted the time to establish a connection with them that might not have been possible if I had taken the history and physical and then presented my findings. I wasn’t thrilled when he first made that suggestion, but it turned out to be pretty instructive.”

“Reading John’s chart before meeting him,” Mark said, “I had a good idea of what he and his wife Janet were experiencing. Foreseeing that Hadley would get the diagnosis right but might be overwhelmed with the psychological dynamics, I decided that I would do the exam to develop enough rapport with both of them to provide a context for what I anticipated would be a difficult conversation. Let me capsulize what Hadley and I know.”

“John is a 43-year-old community college science instructor who developed speech difficulties and increasingly inappropriate behavior last year. His doctor confirmed by gene testing that John had the same rare inherited dementia—*C9orf72*—that had led to his father’s premature incapacitation and death in his 40s. Following a minor motor vehicle accident 3 months ago, John became progressively unable to walk and is now confined to a wheelchair. He stopped teaching at the college because of back pain and his impaired mobility. His doctor could not account for John’s progressing weakness and wondered if he also had ALS, which, as you know, can develop along with the dementia. His neurologic tests including imaging and electrodiagnostic studies are normal.”

“I told Dr. Peters that I’ve never seen someone with this particular familial dementia,” said Hadley. “It’s so interesting. I have to read more about it. John’s thought processes were slow, his speech was impaired, and Dr. Peters’ exam confirmed that his leg weakness was hysterical.”

I knew that Mark, as an astute clinician and teacher, understood how his connection with the patient and his wife was going to be as important as making the diagnosis. I was eager to see how he was conveying his certainty to Hadley.

“Hadley and I are discussing the effect of the illness on both John and his wife and how I used what I heard from them to make my recommendations. We’re putting aside the details of his rare familial dementia for now and have been focusing on the real-life crisis John and Janet are facing.”

“I’m the first to admit that I often feel overwhelmed by all I have to learn about so many diseases,” said Hadley. “The issues Dr. Peters and I have been discussing aren’t on my radar screen, let alone in our neurology

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textbooks. We were just talking about observing someone's body language. After we introduced ourselves, John smiled when Dr. Peters noticed his Denver Broncos shirt and told him he was an ardent Broncos fan. We agree that John's demeanor changed at that point. He gestured with his arms and was excited over the team's latest victory."

"Hadley also noticed that John and Janet used a lot of nonverbal communication."

"Yes! John frequently glanced at Janet to see if she agreed with what he was telling us. She seemed tense and made no eye contact with Dr. Peters. Instead, she looked at her binder filled with medical reports and other information she has accumulated about her husband's illness."

"Just as you came over, I asked Hadley how I began to establish a connection. John had said that he isn't working at this point and was told he has the same serious illness that killed his father. I wondered if Janet was concerned about finances, so I said something like, 'It sounds as if both of you have had much to worry about the last few months.' I also told Janet that I was very sorry for what she's been through and hoped I could help her as well as John."

"I think you got through to her at that point," Hadley said. "I saw her glance at you briefly with tears in her eyes before she looked back down at the stack of records. I never thought about their financial situation."

Mark and I understood that because of John's cognitive problems and lack of confidence, he would be more comfortable relying on his wife to tell his story. "Hadley," I asked, "who actually described the patient's history, John or his wife?"

"Interesting that you asked. Dr. Peters, you first requested that John tell you in his own words about his illness and suggested Janet fill in any details he might have overlooked. Wouldn't Janet have told the facts faster and more clearly than John?"

"You're right, but I wanted to understand John's perspective, not just Janet's. I wanted to hear how he told his story—what he emphasized and what his tone was. You're probably way too young to have heard of the TV show *Dragnet*. Well, the main character, detective Joe Friday, would often admonish a rambling witness, saying 'Just the facts, ma'am.' In medicine, if you use his technique, you lose a sense of your patient's thinking, and if you don't know the family dynamics, that can easily overwhelm your chance of developing rapport with your patient."

I liked Mark's educational approach. He wanted Hadley to appreciate that all patients and family members want a doctor who understands their particular circumstances and makes recommendations that work for them. The facts are only a starting point.

"Dr. Peters, I was amazed by the way John described what had happened to him. He showed very little

emotion for someone who has paralyzed legs. I was also surprised that despite his growing speech deficits and slow thought processes and increasing difficulties, he continued to teach and interact with colleagues until what sounded like a fender bender. Up until then, he had only mild back pain, but over the next week after the accident when he returned to work, his back pain became worse and his legs began to cramp. It wasn't too long before he needed the wheelchair and stopped working. How do you explain all of this?"

Mark replied, "Janet seemed invested in keeping John working. She didn't admit that directly, but she talked about how she and her daughters had to help John get ready and drive him to work every day. She also channeled a lot of her anxiety into learning more about his condition. She kept thumbing through her notebook, giving many details of his genetic disorder she had read about on the Internet. She emphasized that they were all fighters and seemed so defeated when she asked if you were sure that his weakness was all in his head."

"You seemed pretty patient and let her keep asking about particular things she had underlined in scientific articles."

Mark asked, "Did you notice her reaction when I told her that I thought she had certainly done her homework and had learned a great deal about John's illness?"

"She relaxed some, I think. She stopped flipping through the notebook and started looking at you more."

"It was at that point I was able to get her to express her anxiety about her family's future and the financial concerns she had if he couldn't continue to work. She was concerned as to how the family would manage on his disability income and whether she will be able to care for him at home as he becomes increasingly disabled."

I wish I could have taped this whole conversation. It was quite different from what usually is discussed in our neurology conference room.

"Dr. Peters, when you distracted John during your neurologic examination, he was able to move his legs. It seems clear to me that his doctor was right, his paralysis is hysterical. I was wondering how you would explain it. That's not an easy thing to tell someone."

"Exactly! I tried to use different words about his diagnosis from what they heard his referring doctor say."

"Yes, they seemed upset describing how their doctor said John's paralysis was probably hysterical," Hadley recalled. "I can still hear you saying that they must feel their world has been turned upside down by John's illness. You talked about how a person can reach a breaking point that sometimes leads to drastic reactions, including paralysis. They really understood what you were saying when you told them that you've seen extreme stress cause someone to go blind temporarily or be unable to move."

"I did think they heard me differently because I never used the term hysterical. John seemed pleased

that we might be able to reverse his weakness. Janet was more skeptical, don't you think?"

"I had the feeling that even though she had read so much about the disease and even talked to a national authority who was researching this particular genetic defect, she wanted you to come up with a different diagnosis."

"I felt that way, too," said Mark. "That's why I tried to emphasize that with proper treatment we may be able to reverse John's weakness. We also could identify people who could help the family cope with the enormous stress of his disease and her worry that her children might be affected."

"You spent so much more time addressing Janet's concerns. It seems ironic that John has the fatal illness, but Janet needs the most help."

It was the right time for me to excuse myself. Mark and I would undoubtedly talk later about how he had helped Hadley understand that getting the right diagnosis was not enough. She needed to connect with and gain the trust of her patients and their loved ones if she ever hoped to have them accept her recommendations. No matter what time pressures she might feel, some consultations take much longer than planned. It would have been counterproductive to hurry John and Janet, two very vulnerable and frightened individuals. People sense we care about them as human beings by what we say and by our nonverbal communication. To be effective, we have to understand their perspectives before we can address their needs. If we rely on "just the facts," we may be giving them what we think they need rather than what they, in fact, require from us.

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