

In the Patient's Shoes

Chapter 7

The Forgotten Text

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An interesting assignment for my Practicum was to place myself in the patient's shoes. A difficult task, indeed ☹️. The difficulty, at least in my case, is not the lack of imagination or empathy. In fact, the difficulty came after my first MBE year. It has not been uncommon for me to do this type of exercise, partially (actually ☹️), completely my mother's fault 😊. How to live a "correct" life? A very hard question which I don't pretend to answer in the near future, but a question that everyone should be asking themselves on daily basis 😊. Nonetheless, during my human development, my mother taught us a simple rule to cope with the previous question, a dogma which has worked so far for me and I plan to continue "Don't do what you would not like done to yourself". There are similar phrases out there, but the tone and chime that my mother used are embedded like a hardwire. However, for that dogma to work requires another component: cultural competence (>_>). This was embedded in my early years as respect for others and in simple words "We are not all the same, every single one of us is unique...you have to respect that". Looking back, I think that my upbringing was very philosophically based 😊.

Returning to the assignment, if I have done this roughly for 27 years, why do I find this phenomenon fascinating now? Easy, blame the MBE 😊. I don't consider that I have lost my empathic touch; however, I have re-lit the torch of curiosity and insight. I wonder, can I really be in anyone's shoes? There are two types of empathy. Affective

empathy triggers the sensation and feelings towards another person's emotion¹⁹.

Meanwhile, cognitive empathy is the ability to comprehend the emotions of others¹⁹.

Affective empathy seems the easier from the two, at least for me 🙄. If I see suffering, I feel sad, sometimes even helpless when there is not much to do. Now, comprehending another person's emotion, I think that the highest achievement we can reach, is an estimate. In order to really comprehend a parent's suffering when they see their child enduring the adverse effects of chemotherapy, I would need to have the experience of being a parent. Not only that, I would need the memories, the experience of that particular parent-child relationship. Furthermore, I would need to experience the parent's cultural and belief system values.

I found myself that I could *understand* that parents were afraid for their child. They were overwhelmed with their child's condition and the nefarious therapeutics' adverse effects. Yet, could I really understand what they were *actually* passing through? (~_~;) I don't think so...empathy is a close estimation, just like biostatistics can predict the population tendency value through the estimation of a sample. By no means, I conclude that empathy is useless, in fact it is necessary (-(_-)\(^_^)). Empathy helps in patient centered healthcare, as well as intra- and interprofessional communication¹⁹. Nevertheless, I wanted to glaze the surface of a more in-depth reflection...consider the limitations of oneself. Especially when we assume that we are already empathic and

pretend that we can understand 100% how patients feel. Without further ado, I will start analyzing, in the patient's shoes, a few selected cases.

Case of a 75 years old female s/p distal pancreatectomy and splenectomy. Presents for a routine checkup. Her main concern is high blood level pressure, her systolic has remained in 140-150s. She is a current smoker and has a history pulmonary emphysema and arthritis. She is not depressed and knows that smoking is adverse for her health, but it is "hardwired on her brain".

My pre-MBE analysis would be something like: She is alone and is concerned for her health. There must be other factors worrying her. Is she anxious about her family? ...and something along those lines.

Post-MBE analysis...buckle up for the journey (@.@). First, I need to concentrate again(☺ ^ ☺). I have to forget that I am 27 years old female, I have not studied medicine nor bioethics. I am not the eldest of three, nor are my origins from the Caribbean. I have to erase that I am a never smoker and oddly (for the "2 standard deviation in the population" - *poorly attempted a lawyer joke*) (>☺) ... forget the ATV's muddy adventure with my siblings (☺_←), or the asthmatic seal sounds karaoke seasons ☺(←■_■)♪. Difficult...but what I am trying to convey is something similar to the veil of ignorance state by John Rawls.

Now, I need to pick up the pieces off the puzzle, I am 75 years old female. I have kids and grandchildren(☺_☺). The relationship with them is unknown to me. I don't

have that type of insight. I am currently retired and find walking with my friends meaningful in life. I am also a cancer survivor, and smoking is hardwired in my brain. I have attempted to stop before, but to no success. *Am I worried of cancer relapse? I know that smoking is bad for my health, it is linked to pancreatic cancer....* Are those though accurate for *me*, or is it Vivian's medical knowledge slipping into this process? (☹_☹)

Nevermind, let's continue with the exercise: *I feel anxious, my knees are moving up and down while I sit here. I am almost hugging myself, trying to shield myself from the world. I am really anxious... but about what exactly?* And that is when I find my limitation and getting exactly on the patient's shoes. Could it be due to a family member, could it be economical? (••) And if so, what aspect of family? Is someone dying? Do I have a misunderstanding, or do I feel that I am not valued by my family? And so on with the other situations and choices (@_@). What are my priorities? ... My real priorities? Is health one of them?

The same happens when we deliver bad news, and it happened to me. I was on my third-year clerkship, the biopsy returned positive for cancer. I did my SPIKE (as good as third year medical student can do), and I received a blank stare, a poker face...absolutely no emotion at all. Of course, I read (always the blasted books (¬_¬)) that patient's reaction could range from outburst of sadness or anger, to laughing madly to utterly no emotions at all...but seeing it firsthand ...it was unsettling. I found myself in silence, prompting my patient to talk, but we just kept staring at each other. His

wife was quietly crying...I wanted so badly to say: “*Everything is going to be okay*”. And I had to bite my tongue, *remember the coat, remember the coat, remember the coat* (ø_ø). I couldn’t say that, I didn’t know if “everything was going to be okay” and again *Is my “okay”, our okay, your okay?* (._.)(._.) Furthermore, the responsibility to convey truthful information, to not give false hope.

“You are not alone in this; I know it is a lot of information. Do you want to talk about this later?” - He just nodded, and I returned the nod. I gave two steps toward the door.

“Let us know if you have any question or need anything” - I said addressing his wife. Looking back, I should have pushed a little bit more (~_~). I don’t think that I behaved unprofessional or unethically. It could be argued that I respected my patient’s autonomy...he was hospitalized, so there would be more contact. However, I would not be comfortable with my previous approach in an outpatient setting (•_•). I was empathic, I reacted to my patient’s suffering, and I *understood* that the information was too overwhelming and that perhaps he needed time to process the information.... I would classify myself as empathic (at least a close estimation). But I think that I overstepped in the understanding-part(=_=). Was it I, that wanted more time for the information to sink in? I didn’t actually inquiry what he was thinking.... I just assumed that he wanted the information later. Therefore, I unconsciously guided the

conversation under my presumption of understanding, under the pretense of being empathic.

A more estimated empathic approach, would have gathered more information “What are you thinking now?” or “Tell me your thoughts” ...perhaps included his wife in the conversation? Then, empower him to decide when would he like to have the conversation. In the hallway, I realized that I forgot to offer tissues, as per protocol of SPIKES...I practice it, I perfected it with the standardized patient...and yet in the moment of truth I forgot about offering the wife’s patient some tissues. That was my cold bucket regarding bad news.

Few days later, I was exiting another patient’s room in the floor crossing my fingers that I was successful in the explanation (ဘုံ_ဘုံ). My task was to emphasize gently but firmly, that he needed to **STOP EATING AFTER 12:00AM!!!!** (လ(ပံ့ပံ့) This was like the third time that the 9:30am MRI or CT (or whatever study it was) had to be reschedule due to his non-compliance (လ(ပံ့_ပံ့)...“I just get too hungry” - he would say to the team, “Can you schedule it earlier on the day?” Finally, my day was coming to an end \(\^O^\)/ . And I had an upcoming marathonic killer test early next week (ပံ့_ပံ့) . My feet were dragging me to the resident room, when I saw my patient’s wife sitting in an abandoned bed at the hallway, her face shielded from the world, but obviously on distress. I went to my haven (ခ(ဝံ့)...

“I need tissues and a few alcohol pads.” - I said to the nurse in charge.

“For what room? Patients last name and procedure?”

There was a new movement in the hospital, practically for some odd reason MS3 were banned from supply. The nurses were the gatekeepers on each floor(._). Highly understandable considering that Hurricane María barred us from supplies (‘_’).

“Her husband had been recently diagnosed with cancer; she is crying alone in the hallway.” - The nurse looked at me, weighing if what I was saying was reasonable.

“I don’t want to go to her with toilet paper...” - Really, I couldn’t imagine myself going to her with toilet paper(>ლ), because at that specific time there was no paper on the floor; and I could not wait until they restock them. She was in distress now, not later (ಠ_ಠ). Looking back, I could have gone maybe to another floor (•_•;). Maybe I was too tired, or maybe my brain was on automatic (‘_’)\(‘_’).

“Okay, give me a moment.” - in less than two minutes she returned with a few gauzes and three alcohol pads.

I took a deep breath and found myself reciting the SPIKES...I stopped . *Just stop!* \(\^OX)/

The SPIKES is a guide, but I would not base a delicate conversation in a robotic step by step.

“Hey.” - I said softly, bloodshot eyes greeted me. I offered the opened gauze for her to dry her eyes.

“Is everything okay?” - I made a mental slap(>ლ),. I still struggle to find a more neutral form of asking. Conversations are an interesting phenomenon. Despite her distress she nodded her head and said “Yes”. It had happened to me too. I go to the physician’s office because I am not feeling well, and most likely the response I gave when asked how am I feeling, is “Good” (☹ _ ☹). It could be cultural; it could be a defense mechanism...

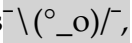






“Is there something that worries you in particular?” – I asked, extending my hand offering 1 opened alcohol pad. Now this is interesting, I don’t know if there is scientific evidence behind smelling alcohol and aiding with stressful situation, but it is something that I have grown into ▯ (‘•_•’) ▯. You have nausea, here is your alcohol pad? (☹.☹) Did you passed out, just sniff an alcohol pad? (ò.ó) Are you in a distressful situation (not the kind of “I am going to take a test soon” situation), enter the alcohol pad(☹.☹) ^q.

She explained that she had a close encounter with cancer during the past years, and it was overwhelming to know that she would need to be in that pathway once again. She was also worried for her husband; he was too quiet for her liking and couldn’t decipher what he was actually thinking. “You know, he is the stronger out of the two for this type of situation. He is the one always reassuring, giving me strength. But now seeing him like this...” – her voice broke and she started crying.

^q A weird type of cultural-informal “aromatherapy”. See Sniffing alcohol is thought to be a good cure for nausea by Bakalar²⁰. However, regardless of the intervention success (whether sniff calms anxiety or not), the essence is the cultural competence and let the patient know (in this case the patient’s family) that they are more than just a disease, that the team cares for the person suffering from the disease.

I placed my hand over her shoulder, I just wanted to let her know I was there, that somehow, I understood her pain, her suffering. I noticed that she had a crucifix. “Do you participate in a religious group?” She nodded. “I know that this is a hard situation and from what you are telling me, you and your husband could benefit from having external supports that goes accordingly with your belief of system”. I remembered that she had a blank stare. “Yeah, we are Catholics.”

It would have been easier for me, to just say what I would say to a close one (••). Because I would not need to consider the boundaries of professionalism, I would simply say “God will not abandon us...” or “You are in our prayers”. However, I believe that would be incorrect, my function as a physician-in-training is to deliver and apply the medical information with care (which means that I am not treating only the disease but a whole person) (•_•). Nonetheless, due to the nature of the relationship: the patient is vulnerable, the physician has a greater knowledge regarding the conditions and treatment, etc., I have to be careful of what information I provide and how I deliver that information as well (~_~). If I were in my patients’ shoes, personally I would not like that a religious topic nor belief would be imposed(._.)(._.); that is something that I would rather find in my privacy. I would not mind that chaplain services may be offered, but I am conscious that I am not exactly seeking spiritual counseling from my physician (☪_☪).

I remember one time, with a close one where the physician said, “Well” – he said, trying to put the *puppy eye-I-am-so-so-sorry-face* “the only thing left is pray.” I don’t know if he was serious , a failed attempt to empathy  or a mix altogether . What I do know is that I was barely in my teens and I frowned (and still do) at his “medical conclusion” . Half of the family believed he was mocking the religious belief , the other one gave them benefit of the doubts . I was on the “mocking-team”, years later and seeing myself struggle, I am inclining myself to give the benefit of a serious, well-intentioned attempt to be empathic .

“Would you like that the hospital’s Father came and talked to you?” She nodded.

I could not imagine what the couple was passing through. These types of news are a struggle during the time we had “normal” communications, but now with the after-effects of the Hurricane, patients tended to be lonelier at the Hospital, most of the time severed from their support system.

“If there are other questions or concerns, ask us. If we don’t know the answer at the moment, we will search for it. The important thing is that you are not alone in this”.

A few tears spilled from her eyes, she nodded and muttered a “Thank you”. I gave her the remaining gauze and alcohol pads and squeezed her shoulder.

[†] The Berman Institute’s lower level (physically-the basement) hosted most of my bioethical courses, but it also held many seminars and activities (like the white elephant). On November 8, 2018 Dr. Dariusz Galasinski gave a presentation in the Share *Decision Making Symposium*, hosted by Dr. Zack Berger. He critiques the physician’s attempt to empathy, which involved something along those lines....

I returned to the resident's room, I was definitely going to take a nap, before even trying to read another chapter of who knows what part of the body (✕ ∩ ✕). "How do you call the catholic chaplain?" They looked at me like I had grown another head (◎_◎). "Is someone dying?"

"No." - I blurted out.

"Ah, okay." – said my resident relieved, letting go the breath he was holding. "I don't know, but I don't think he is around at this hour. We need to talk to the nurses tomorrow and see how the process is. I have never called a chaplain before".

So yeah, for some odd reason chaplaincy (at least from my rotation experience) was seen as something foreign to medicine (@_@). It was quickly associated with a dying patient, and sometimes even looked upon "*as a waste of time*" (>☹). This is highly contrasted during my MBE practicum(☹_☹✕); chaplaincy is regarded as an official consult team. Consults are placed just like you would place a consult to any other service. This was crucial for the health care of our patient. Physicians are known for their curing role, sometimes we forget that we also have a responsibility to heal²¹ And as my thesis also suggests, physicians have other roles. I believe that in order to heal it is essential to take care of the whole person, including their spirituality. However, since the spirituality domain is out of the scope of the medical training; the chaplaincy service is necessary (just like Social Work consult when physicians mitigate the determinants of health).

I don't know what is happening in the rest of the world $\neg _ (\text{ツ}) _ /$, but at least during my professional rising (specifically hardcore biology courses), there has always been this invisible vehement battle trying to prove that God does not exist (and some proof that physicians are godly incarnations) (\neg, \neg) , instead of focusing on making new discovery $(> \text{ლ})$. I remember one time when a lecturer (who was not an MD) bitterly declared, "Oh now I am in the presence of the "Medios Dioses" (which literally translate to English as *half-gods (demigods)*, well I am a doctor too". $(\odot _ \odot)$

"Yeaay! Woo! Welcome to the Olympian team $(\neg \text{ o } \neg)$ " I didn't see the logic then, I was too tired and my mind was already thinking about "Match Gabapentin-Diagnosis Quest" $(\text{ଓ} _ \text{ଓ})$ and the difficult decision between pork ramen or chicken ramen for the evening (\neg, \neg) . After having two philosopher mentors shaping the way arguments work in the MBE $(\text{ଓ}' \bullet _ \bullet \text{'ଓ})$, I fail to see the relations between the claims $\neg _ (\text{°} _ \text{o}) _ /$, and I highly question the contents of the premise $(\text{o} _ \text{O})$and no I am not going to bother to search the hidden premises either $(\smile \wedge \smile)$. Some arguments are better left in the dark $\neg _ \odot _ \odot _ /$. I think, however, this is another manifestation of the *transformation hysteria thingy* that was discussed in Part I. It was seen in the people that I encountered that pleaded for my Neverland visa retention $(\odot _ \odot)$; it was also seen in the third year "gloriousness" referral $(\text{ଓ} _ \text{ଓ})$ and also throughout some personal experience where the physician's recommendation sometimes felt like the final saying in the conversation

(☹☹). I wonder, how much this language and/or attitudes embedded during the transformation process towards a full professional (ʘ☹☹ʘ).

The last case was a pediatric case. During the MBE there was a Fall submission in 2019 that called for a short piece in *Reflections on Trauma*. The title is [One Hug Away from Home](#). [Side note: It was accepted for publication on 2020 by Tendon Magazine!

ヽ(^o^)/] Unlike the previous two examples, this piece was actually a wake-up call from my patient.

References

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