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Talking About Patients in Front of Them

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I OFTEN HAVE STUDENTS with me when I see patients. These may be residents, fellows, medical students or the occasional health professional like a pharmacist, nurse or therapist. Obviously, they are watching in order to learn, both from simple observation, getting to see patients with



a variety of movement disorders whom they would otherwise not see, but also from my making salient observations and explaining their importance. I think doctors and students often have mixed feelings about talking about patients in front of them. Patients don't like to be regarded as specimens, to be discussed as statistics or as pathological cases.

However, I am of the opinion that patients do like to know about their condition, and, I believe, how and why I think what I think, and why I do what I do. Listening to a discussion about what a sign means, what the pathophysiology is, what the management issues are is like watching a movie about the making of a movie where the patient is the subject. It's a behind the scenes look that is, for those of us not used to being behind the scenes, enlightening, and equally important, reassuring. In addition, it makes me look smart, to have some clearly bright, young adults listening, hopefully with rapt attention, to the graybeard sage opining. The important

point is how one does this in a manner that avoids the patient feeling like a slab of meat.

The first thing I do is to tell the patient and family that I'm going to teach the students and that I'll try to make what I say understandable to the patient, since he is part of the audience, as

well as to the medical personnel. Since many of my patients and their families are hard of hearing, I will talk loudly enough for them to understand. In these sessions I never say anything ominous, and never describe things in pessimistic terms. I will only note worsening when the patient or family is quite clear that worsening has occurred. I will try to interpret that worsening in terms of functional impact to the patient, possible pathophysiological explanations and potential treatment options. I then ask the patient and family if they understood what I discussed and attempt to answer their questions.

I have not questioned my patients about this teaching but I have always felt that they like it. They are treated as part of the scene, important parts of the scene, and we can share their pain as we try to understand their problem and thereby, its treatment, in as humanistic and scientific a manner as possible. I also think patients and families like to know that their doctor is teaching other

doctors about their condition. Someone more knowledgeable than others is presumably, treating them, the person to whom others turn when there are questions. And many will ask, "How else will they learn?"

Not all discussions are held in front of the patient. I usually don't quiz my students in front of patients, although I sometimes do. If done with sensitivity this can be very rewarding, especially if a wrong answer or a silence can be turned into a small jest, and the atmosphere is not intimidating. Patients will always take the side of the student, so arrogance and pedantry are even worse in this setting than it is in private.

My evaluation of a patient for the first time, if done in front of students, is generally discussed outside the room where the patient cannot hear or see us. This allows for discussions best not heard, where someone might question a previous treatment or diagnosis, where an illness may be discussed in frank, sometimes brutal terms. I have learned over many years that students almost always underrate the functional impact of Parkinson disease, so that it is part of my obligation to point out that the minor tremor or reduced dexterity might mean the loss of a career within the next few months, or that the seemingly minor hallucination may portend something far more severe on the near horizon. Or we may discuss the role of a family's wildly dysfunctional state on the patient's ability to cope with a

disability. These are important topics, but best aired in private.

There are, clearly, reasons for private discussions, but I think the utility of a discussion in front of the patient is often undervalued. The residents who are new to my clinic often ask if I would prefer having the case presented in camera or in front of the patient. I always require a presentation in front of the patient. This is, I strongly believe, highly reassuring to the patient, because he then knows what I heard and doesn't have to worry that I came to an incorrect conclusion because of an inaccurate history by a trainee. It is also useful for the trainee to present findings that might be quite

worrisome in terms that convey the gravity of the problem without the severe prognostic implications.

Medicine, especially in the specialties, as it has become increasingly test dependent, can divorce the patient from the disease. This is much less stressful for the doctor and also easier for the teaching of medicine, but bodies are not like cars and doctors are not like mechanics. As a prominent advertiser of men's clothes was wont to exclaim, "An educated consumer is our best customer." That applies to medicine as well: having educated students and educated patients is the goal. ❖

Author

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