

## Into the Ether

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I GENERALLY HAVE NO idea if my columns are ever read. I assume that some readers scan at least the first few sentences, and hope that some will even read the whole essay. I sometimes fantasize that many people will do so and will then contact their friends and relatives to create a gigantic tsunami of “hits” on the journal’s website, but know this is just that, a fantasy. About 10 years into my stewardship of this journal and my monthly columns, I considered the question I’m writing about now, i.e., does anyone read this? I noted that the Journal, then issued in a print version, was sent to the 1700 or so members of the RI Medical Society, and was also delivered to the mailbox of every Brown medical student. I noted that after 10 years no medical student had ever come up to me after a class (I give 1–2 lectures/year, and used to run some small group discussions) and ask if I was “the” Joseph Friedman who wrote a monthly column in the Journal. I deduced that my columns were rarely read, and those who read them were never impressed enough to find out, or remember the name of the person who wrote them. And then, about six months after reaching that conclusion, a student came up to me at neurology grand rounds to let me know that he had read a recent essay, so that at least one



person had. I was pleased.

Recently I received an email summary of citations and “hits” on my publications. This came, unsolicited, from the publisher of one of the journals I’ve had articles in. On the positive side, my citations total was substantial, but this included several articles

in which I was one contributor of a hundred or more for multi-center drug trials in which I was the principal investigator at Brown. Still, that was nice. On the other hand, a recently published editorial I had been asked to write had not had any “hits.” Zero. It would not have been possible to have any citations, since that requires an article to be published in which my article was cited, and not enough time had passed. However, the lack of any “hits” was definitely unnerving, making me wonder, even as I write this, whether anyone is going to read it. My second thought, as I was then involved in writing a critique of someone else’s article, was that no one would care what I wrote because no one was going to read it, so why should I spend time worrying about how to phrase a criticism in order to not offend a professional friend and colleague? And then, the fundamental question, why the heck should I write anything anyway? Most of us, myself for sure, are sufficiently egocentric that we like to

see our names in print and score points on our curriculum vitae but the value is undercut if no one reads what we write and we actually can determine that fact. When I think of the narcissistic quality attached to being a published author, I always think of the famous quote from WH Auden, the great 20th century British poet, who counseled writers to always type their work as authors tended to like the appearance of their penmanship, much as they relished the smell of their own gas.

Until I received the notice summarizing my citation history, I had thought that the article I wrote that had received the most attention was one on yawning in a person with Parkinson’s disease (PD). This was a single case report of no great educational value, and deserved publication primarily as a “believe it or not,” sort of case. It turns out to actually have some potential physiological value in that one dopamine agonist, but not any others, including L-Dopa, produce yawning in people with PD routinely, whereas my patient was the first reported in which yawning was not due to this drug. Nevertheless, this was more interesting than valuable. Yet there were letters to the editor and some interest, more than for papers I wrote that actually had clinical import.

But I was rescued from my citation doldrums when I read a case report in which the authors noted the presence of the “runny nose sign” to help confirm a clinical diagnosis of dementia with

Lewy bodies, a form of PD. It was a sign I was the first to describe in print. I didn't think to give it a name, and merely called it, "rhinorrhea," since that's the technical term for a runny nose. I thought it mildly important as another sign of sympathetic denervation in PD, a finding which might function as an additional "pre-motor" sign of the disease, that is, a feature, which, along with several others, increases the risk

that an older person will develop PD in the near future. I had not thought of it as a sign that might help confirm the diagnosis of PD or related disease. I was ecstatic to be cited, but I am hopeful that the "runny nose sign," proud as I am at having identified it for the first time, will not be replaced by an eponymic. This is not a sign to be proud of. I also continue to worry whenever my nose runs for a few days. ❖

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[Disclosures on website](#)

## LETTER TO THE EDITOR

### AMA Urges EpiPen Manufacturer to Rein in Exorbitant Costs

On Aug. 24th, Andrew W. Gurman, MD, president of the American Medical Association, issued the following statement regarding the cost of EpiPens, which have risen to more than \$600 for a twin-pack:

"With Americans across the country sending their children back to school this month, many parents and schools are encountering sticker shock over the cost of EpiPens. Although the product is unchanged since 2009, the cost has skyrocketed by more than 400 percent during that period. The AMA has long urged the pharmaceutical industry to exercise reasonable restraint in drug pricing, and, with lives on the line, we urge the manufacturer to do all it can to rein in these exorbitant costs. With many parents required to buy two or more sets of EpiPens just to keep their children safe, the high cost of these devices may either keep them out of reach of people in need or force some families to choose between EpiPens and other essentials. The AMA will continue to promote market-based strategies to achieve access to and affordability of health care goods and services." ❖



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## Role-playing in Physician-Patient Relationships

HERBERT RAKATANSKY, MD

**M**EDICINE IS A LIFE-long learning experience, much of it from specific incidents.

Initially I started a solo practice and made an arrangement with Dr. S, a more senior physician (all other physicians were more senior), to alternate nights and weekend coverage. One night Dr. S informed me that that a patient of his was terminal and might expire that night. He was being cared for at home by a nurse and other caregivers. This was before Hospice came to RI (1976). I was informed that the family was fully aware and that if the patient died that night Dr. S would sign the needed papers in the morning and that there was no need for me to make a house call. Yes, we once actually made house calls. And I also was told that the family understood all of this.

Indeed, I received a call at about 1 AM that night. I spoke with the nurse and a son of the patient and confirmed that the patient had died and that there was no need to personally "show up." Just after I fell asleep about an hour later, the phone rang again. The son was on the phone asking if I was coming. At this point I considered two issues. First, the family was upset and second I was afraid of feedback to Dr. S that my response was less than satisfactory. After all, Dr. S was a well-respected member of the medical



community and as a medical neophyte I wanted to impress him. So I made a house call. When I arrived (by now it was well after 2 AM) the funeral home attendants were waiting with the hearse outside. The son was waiting anxiously at the door. A hospital bed had been installed in the living

room and the patient was lying there surrounded in a semi-circle by members of his family and a uniformed nurse.

And then, in a sudden insight uncharacteristic of my medical youth, it dawned on me why I needed to be there. The patient was not "really" dead until pronounced to be so by the doctor. Medical school, residency and fellowship had not prepared me for this eventuality. I thought of similar situations in the movies. Then, projecting a serious demeanor, I felt for a pulse, listened carefully for a heartbeat and auscultated the lungs. Finally I turned to the son and told him that I was sorry to inform him that his father had died.

He and other family members were very appreciative of my attendance and thanked me profusely for coming. As I left the house the funeral home attendants were coming in with a stretcher.

The lesson I learned that night was that I had played a necessary role in the family's narrative of that patient's death. Had I not made the house call

there would be a sense of the process being incomplete. Since then I have been aware of other times that I played roles as I cared for patients and their families.

At that point in my career I was younger than most of my patients. I cared for many who were the age of my parents and even my grandparents. If I looked for the signs, I could see them regarding me as a son or grandson. Rather than resenting their view of my youth I incorporated it into my therapeutic approach. I could be the son, now a successful doctor. And currently I can be the wise grandfather caring for my younger patients. (It is not the patients' age that has changed).

Role-playing may be very simple. Wearing a green item on St. Patrick's Day will send a message to Irish patients that you respect the holiday and that you temporarily are "Irish." That connection can only be therapeutic.

In training we are taught about transference (feelings projected by the patient onto the doctor) and countertransference (unconscious feelings projected by the doctor).

Freud (1910) first described countertransference as "a result of the patient's influence on (the doctor's) unconscious feelings." The term refers to unconscious reactions to a patient that are determined by the (doctor's) own life history and unconscious content.

Some, starting with Freud, interpret the seemingly conscious decision to role-play as due to unconscious feelings

of the doctor, the doctor's own needs and unconscious perceptions of the patient's needs (countertransference) thus calling into question our ability to freely choose to role-play.

Our understanding of transference and countertransference in psychotherapy has evolved. It may be helpful or destructive. Hanna Segal (1918–2011) stated: "Countertransference can be the best of servants but is the most awful of masters."

An example of countertransference: "A therapist, who was about to get married, worked with a client in a troubled marriage. The therapist continually encouraged the client to stay with her husband, admitting in one post-session interview, '*Marriage is wonderful. It will all work out fine in the end.*' "

Our role, both self and patient defined, is always as a doctor, but with variations. Role-playing can be a conscious behavior (Freud notwithstanding) that enhances the patients' interests. Opportunities may occur in an individual, group or cultural setting, as in my sentinel incident.

The role must be consonant with both ethical standards and the personal values of the doctor. For example: a doctor should not endorse racist or other hateful viewpoints held by patients.

Role-playing should be focused exclusively on the patient's needs. If it benefits the doctor's personal needs (countertransference) it may become a detriment to the therapeutic relationship. In that instance re-evaluation of the role along with consultation and insight

oriented counseling may be helpful for the doctor. Personal self-awareness and an understanding of these issues are important patient protection measures.

Still, I believe there is a place for conscious socio-cultural-personal enhancement of our role as doctors (role-playing) based on our assessment of each individual situation.

It all sounds a bit paternalistic, but enhancing lives is what parents do. ❖

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