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I hate to run late.

I can’t say it is an obsession, but I become uncomfortable when I make patients wait. Most of my patients appreciate this because I am, evidently, an uncommon physician, in that I run on time. When I run late, it is usually because a patient arrived late, for a variety of reasons, almost always unavoidable, and not indicative of moral turpitude on their part. And, of course, some people have difficult problems that take longer than scheduled. However, there is a small number of patients who are simply so talkative that it’s hard to run on time. They drive me nuts.

As background for this essay it is important that we understand that M.D. stands for medical doctor and not medical deity. In a famous study (Ann Int Med 1984;101(5):692-6) 74 office visits were reviewed, in which only 23% of patients were able to complete their initial statements of what their problems were, and the average amount of time before they were interrupted by the doctor was 18 seconds. Unfortunately, these findings have been confirmed in other reports, indicating that too often the medical deity has taken charge. A physician needs to be sensitive to the needs of the patient, just as the patient needs to be sensitive to the fact that there is usually another patient waiting to be seen.

Recently I saw a patient whose pressured speech was clearly part of the syndrome for which I was being consulted. It reminded me of a similar patient decades ago who was the first I directly confronted by telling her that her non-stop talking was, in fact, part of her problem, and that she needed to stop for a while so that I could compete my evaluation. I was able to get her admitted to a psychiatric hospital and then visited her to find out how she was doing. When I met her on the ward, I didn’t think she’d remember me because she had only met me the one time and she was “hyper,” to say the least. “Of course I remember you. You’re the doctor who told me to shut up,” she said with a broad smile.

Handling talkative patients is probably an art. I found some articles on this, but, quite frankly, they were not informative. Perhaps because it was a distillation of suggestions from “good” doctors, discussing how they handle patients in a primary care setting who are excessively talkative. A common suggestion was to tell the patient there was only a limited amount of time, and if they didn’t cover everything they’d have to come back next week. Obviously this was in Europe, not the U.S., where a “visit next week,” is not an option.

There are several reasons for patients to talk “too much.” Mania or extreme anxiety produce non-stop talking, which is clearly part of the problem itself, and becomes part of the examination findings. The more common causes for talkativeness are conceit or self-absorption, and presumed concern that an important aspect of the history will be overlooked. This tends to occur in the highly educated, often with scientific backgrounds. “I just thought that the fact that the taco had hot sauce on it followed by a cola might explain why I was feeling the pain, whereas the week before I didn’t get it when I hadn’t had the cola, although I had the first for lunch and the second for supper.” And, of course, some people are simply non-stop talkers. Every history involves the friends, in-laws, time of day, and God-knows what else.

First of all, I always give people some time to think. I always have the 18-second and 23% completion-of-complaint rate firmly in my consciousness as a measure of bad medicine. Yet, to be honest, histories are, in fact, not that terribly useful in my line of work. The exam is generally much more important, and usually trumps the history if the two are not in alignment. Nevertheless I always take a detailed history. How do I do this in this setting? Generally I apologize for interrupting. “I’m sorry, but I’m having trouble keeping
track of all that information. It will be much better, since I’m taking notes, for me to ask you some questions in a particular order, or I’ll get lost. If I don’t cover something important at the end you should tell me about it.” This approach, I’ve found, coupled with my age, allows me to take charge, and in a way that saves face. This doctor is limited in his attention and needs to focus. Sometimes I say that I have to behave like a lawyer to make sure I “get it right.” That means that I need to ask the questions to get information to line up in a logical sequence. I need to not be distracted. This approach, I think covers all rational people. Even when the talkative ones start getting carried away I can use the same approach to apologize for my own needs, my own peculiar way of getting information that I can use. Unlike the recommendations of the European primary care providers, I don’t say that we have limited time. I don’t say that there are others waiting. Patients do not want to hear that their doctor is too busy for them, especially if they may have waited two or three months for the appointment.

Some of my patients bring lists of their problems. I encourage this as it makes it less likely that something will be forgotten, but I like to take the list and review it myself. This keeps the list from turning into a collection of bullet points for a lecture that could go on forever.

Patients like to be heard. Their problems need to be considered and validated. I believe that as long as this happens, time constraints should be implemented politely, which will neither demean nor affront the patient.

Easier said than done, unfortunately.

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The persistence of racially-based health care inequities

HERBERT RAKATANSKY, MD

There is a statue of Dr. Marion Sims (1813–1883) at 103rd street and 5th Avenue, across from the NY Academy of Medicine. Other statues of Dr. Sims are in Alabama, South Carolina and France. Dr. Sims is remembered for devising an operation that cured vesico-vaginal fistulas, a condition resulting from injury during birth resulting in continuous and uncontrollable urine dripping from the vagina. Dr. Sims also later established the first hospital devoted to treating women’s diseases.

The experiments started in 1845, a year before anesthesia was discovered and were performed on slaves sent to Dr. Sims with the hope that a cure would enable them to return to work. Although anesthesia was widely adopted starting in late 1846, the AMA did not approve it until 1849 by which time Dr. Sims had finished his experiments without using anesthesia. But even then, Dr. Sims did not use anesthesia on either white or black women. This seems incredulous today, but some belief patterns are difficult to break. For example, some doctors and some members of the clergy felt that anesthesia should not be used during childbirth. Dr. Charles Meigs of Philadelphia stated that painful contractions were “natural and physiological forces that the Divinity has ordered us to enjoy or suffer.” That attitude lost traction after Queen Victoria used chloroform for her 8th delivery in 1853.

As with other statues and memorials of well-known military and political persons who endorsed racist beliefs, many people believe that the statue of Dr. Sims should be removed.

Much of the Sims’ experimentation was on three slaves (Anarcha, Betsy, and Lucy). Dr. Sims wrote that his success was due “to the indomitable courage of these long suffering women, more than to any other one single circumstance.”

But were the women really volunteers? They were restrained forcibly during the operations and likely had little choice. Informed consent, as we know it today, did not exist, though Sims stated that the women consented. But whatever consent was obtained would have been from the slave owner. The women themselves had no legal power to consent or refuse.

One defense of Dr. Sims by those wishing to preserve the statue is that he did what was right in the time and society in which he lived. But that argument could also be used to excuse the Nazi doctors who are remembered today only for their horrific experiments. There are, of course, no statues of them.

Was Dr. Sims a racist? He owned slaves but set them free in 1853, ten years before the Emancipation Proclamation. In 1876, Dr. Sims was president of the AMA. In his presidential address he welcomed the first woman delegate (Sarah Stevenson). Sims also welcomed “any colored man [who] should rise to the dignity of representing a…Medical Society.” In spite of this personal welcome, the AMA refused to eliminate race as a criterion for membership.

Membership in the AMA (formed in 1847) was obtained until modern times only through membership in a state or county medical society and most of these refused to admit black doctors. A very few black doctors became AMA members in about 1880 but the first black delegate was not admitted until 1950. The RI Medical Society admitted Dr. James A. Gilbert in 1895, who thus became an early AMA member (though not a delegate to the AMA annual meeting). Even the Flexner report in 1910 endorsed segregated and less rigorous medical education for blacks.

In 1963, the RI Medical Society AMA delegation proposed excluding discriminatory state and county medical society from AMA membership. The AMA rejected this proposal. Explicit racial discrimination at the AMA ended only with the civil rights law in 1964.

In 2008, the AMA formally apologized for its previous racist policies.

It is well known, but sad to remember, that biases have not been limited to skin color. In 1950 [as reported in the Providence Journal] a black doctor
in RI applied for an internship and was told, “I can’t accept you, [but] I’d rather have you than a Jew.” One black doctor reported he could not get on the staff of any Providence hospital while two others were accepted.

Disparities in health care derive from many factors, including but not limited to insurance status, income, access to health care facilities, lack of coverage by some health care plans, lack of minority representation on governance committees of the health care system, and racial biases in the health care system itself.

But do doctors themselves have racial biases about patients? Most of us professionals [doctors, nurses, etc., including me] believe that once patients are actually in the “system” they all will receive equal treatment.

But this may not be the reality everywhere. There is evidence that some persons believe that blacks have specific biologic characteristics and these beliefs influence their treatment. Black patients may receive lower doses of analgesics than whites. Black children with appendicitis were less likely to receive any medication and when they did it was less likely to be an opioid. In patients with cancer pain 35% of “racial minority” patients received World Health Organization suggested doses of pain medication while 50% of “non-minority” patients received the suggested dose. While pain in black patients may be undertreated because doctors hold false beliefs about blacks, the doctors who undertreated the black children did not espouse other racist opinions. They believed the pain in blacks was less severe.

In a study reported in 2015, 223 medical students and residents endorsed, on average, 11.5% of a list of 11 false beliefs about race.

50% of these medical students and residents stated that at least one of the false beliefs was at least possibly true, compared to 73% of a control group of non-medical persons. Omitting the opinions of first-year medical students [with less training] did not change the results. Treatment recommendations demonstrated that black patients would be under-treated by those endorsing false beliefs.

Among the 11 false beliefs were:

“Whites on the average have larger brains than blacks.”

“Black people’s nerve endings are less sensitive than White people’s nerve endings.”

Thus getting into “the medical system” may not guarantee equal treatment for black patients, though I have not personally observed this. Correcting socio-economic conditions is a public responsibility that needs urgent attention. But the medical profession itself needs to be diligent in addressing its own occult racism.

Getting back to the statue; if it is removed we will cease to honor Dr. Sims publicly. Women will, of course, continue to benefit from the procedures he invented.

Replacing the statue with one of Anarcha, Betsy, and Lucy would honor them and remind us of the racial biases and inequities suffered by black [and other minority] patients.

With or without a statue of them, however, we honor these women best by studying the causes of racially-based health care inequities at all levels and working to eliminate them, thus improving “the system” so that every patient is treated equally, regardless of skin color.

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