

On Mentors, Epitaphs and Patients. What it takes to become a beloved physician.

by Jerry Byrum M.D.

It is interesting how a simple question can profoundly affect you. Last summer, as I sat in a conference center, the leader of a seminar passed out a sheet of paper with a drawing of a tombstone printed on it. He asked us to write our names on the tombstone, the date of our birth and then the date of our death if we were to live eighty years. Because I turn forty this year, there was quite a bit of symmetry to those numbers. The leader then asked us to write two other things on our “tombstone”. The first was to write the epitaph that would be written by our family if we were to die that day. The last thing was to write the epitaph that we would like to have written about us. This was such a simple exercise and yet it really caused me to think about my life. It is interesting that we use a little dash between two numbers and a few simple words to summarize one’s entire life. It is also interesting how much those few words can say about a person.

As I thought about it, one of the few things that I wanted to be written on my tombstone was, “beloved physician”. I found it very interesting that I didn’t particularly want it to read “competent physician” or “rich physician” or “busy physician” or “important physician” or any other adjective. I found that I just wanted it to read, “beloved physician”.

I then contemplated on what it meant to be a “beloved physician”. I realized that a lot went into being a “beloved physician”. I then remembered some of my mentors who had invested in my life as a physician. I thought about their contributions, how they had taught me so many things and how much I appreciated them.

First, there was Dr. Roger Bost, a distinguished pediatrician who after practicing pediatrics for years, later served as AHEC director. Before retiring from medicine, he then spent several years as a professor of pediatrics at Arkansas Children’s Hospital. This interval of time happened to be during my medical school and pediatric residency years. Dr. Bost had a way of carefully listening to a patient’s or parent’s concerns, coming to a conclusion and then clearly and very directly explaining what needed to be worried about and what did not. Dr. Bost taught that you should treat the patient in the way that is best for them, not treating that patient based on their expectations nor on the expectations of the parents. This approach may take a little extra time as an understanding of one’s condition comes with explanation.

Hundreds of times each year, I explain to parents why antibiotics do not help viral upper respiratory infections and how antibiotics may actually do more harm than good for these conditions. There are many other examples of times when it is so easy to knuckle under to the wishes of demanding patients, when those wishes may actually do them harm. Dr. Bost helped me learn how important clear, direct communication and sound medical decision making are to a doctor. You see, a “beloved physician” does what is in the best interests of his patients, even if those patients don’t know what is best right then. Over time however, patients will realize if their doctor cares enough to do what is best for them.

My next lesson came in a very different environment. I will never forget my first overnight call in the UAMS intensive care nursery as a second year pediatric resident. That particular day had been very busy with the births of several extremely ill neonates. Born that day were infants with meconium aspiration syndrome, sepsis and prematurity with Hyaline Membrane Disease. There were about 8 patients in the Intensive Care Nursery on mechanical ventilation in various stages of these three

diseases. The patients ranged from 600 grams to 4,000 grams. This was a daunting task to manage these very ill neonates overnight on one's first night of Intensive Care Nursery call.

On this particular evening, Dr. Bob Arrington, the chief of neonatology at UAMS was the staff neonatologist on call. As arterial blood gas determinations were made on these ill newborns, ventilator changes were needed as the disease processes played out on each individual child. It was my job to direct those changes. Because of inexperience at ventilator management of premature lung disease, sepsis and meconium aspiration, I didn't realize that different conditions and different size babies would demand different arterial blood gas tolerances and hence different ventilator management plans. After about two or three calls to Dr. Arrington, with what I am sure were perplexing questions, Dr. Arrington came unannounced to the UAMS nursery. Instead of managing the patients himself and then getting sleep, he spent three hours with a young resident at 2 am, explaining the differences between ventilating a 600 gram baby with premature lung disease and a 4,000 gram infant of a diabetic mother with meconium aspiration syndrome. I learned more in those three hours than any other three hours in my life. The knowledge and skill that I received during this time, was not just about neonatology. I learned the importance of knowledge and skill to a physician in a general sense. To be a "beloved physician" requires that we learn and that we are technically good at what we do. It means that we gain and maintain technical competence and stay up to date. Otherwise, even with the best of intentions, we do harm to our patients.

Another lesson learned during my training in pediatrics came at the hands of the chairman of pediatrics at Arkansas Children's Hospital, Dr. Robert Fiser. Dr. Fiser would usually attend "morning report" each morning. During this time, the workups of patients who were admitted to the hospital in the previous 24 hours were presented to him, a group of staff professors and of course, our peers. This was a great teaching time, when cases were presented and there was discussion about the patient's condition, differential diagnoses and treatment plans.

It did not take long to learn that one needed to be fully prepared for this moment with a spirit of excellence. I learned to invest enough time in each of my case presentations so that I knew about the condition, the differential diagnosis and the currently accepted treatment. Not preparing in this way was a sure way to disappoint our chairman, which no one wanted to do (for several good reasons which we will not go into here). Even now, it is interesting how fruitful this same approach is in treating my own patients. During this time of training, I learned where and how to find the facts fast and to do it with a spirit of excellence. I learned not to take shortcuts in managing my patients, but to give excellence to each and every patient each time, no matter how tired I am. A "beloved physician" treats his patients with this spirit of excellence.

It was with these lessons of training, all well taught and well received, that I began my own practice in pediatrics. Shortly after entering practice however, I caught my first glimpse of another aspect of practice that I had not been taught up to this point. This first lesson on the subject came from one of our close family friends who has four children. As I entered pediatric practice, she made a comment that she did not want to hurt my feelings, but that she would not be using me as the pediatrician for her children. I had never expected her to change from her pediatrician, because she had an established relationship. I understood that clearly. But then came the lesson, "you see, this doctor kisses my child on the head." At first, that comment took me a bit by surprise. What did she mean by it? For a while, I dismissed the thought. However, with time I began to understand what she meant. This last attribute involved in being a "beloved physician" is what I want to discuss now.

Not long after I entered practice, a young woman was run over by a car in a hospital parking lot. She was pregnant with her second child. For some reason, the family informed us of the accident shortly

after it happened. Because I was her little girl's pediatrician, I decided to check on this woman in the hospital a couple of hours after the accident. As I walked into the room, I could hardly recognize her because of the trauma. However, she was alert and immediately recognized me. With a look that I will never forget and words barely audible but extremely intense, she said, "pray for me, pray for me". And so, the best way I could, as the general surgeon was placing a chest tube, I prayed out loud for her and this unborn child as I held her hand. A few hours later, I was the one who was handed a 30 week premature baby at emergency C-section. Miraculously, for thirty minutes after birth, the baby had no sign of respiratory distress and this mother got to have the baby next to her as she experienced the joy of the birth of her son, despite her pain. I'll never forget that experience. Neither will she. I learned something that day, a "beloved physician" strives to meet the needs of his patients. Somehow, after this experience, it seemed that my practice really began to grow. It was interesting that many of my patients seemed to know this woman and each other. I wonder why.

With time, in our clinic we began to implement several simple strategies to connect with our patients. We began this task nine years ago by compiling and reading the best pediatric patient handbooks from across the country and then writing our own version with the best ideas from each one. In our handbook, which is in its third edition, we communicate with our patients about our practice philosophy, parenting skills, medical advice for common pediatric illnesses, medication dosages, practice policies and procedures and other helpful insights. We find that our patients want to hear from us, their own doctors, and not necessarily from some pre-printed material. When our patients and parents read our handbook, it is like they are speaking with us. This communication tool is of great importance to our practice; educating our patients, preventing unnecessary office visits and diminishing our telephone calls.

Over time we implemented good charting techniques in our office. We designed a form which makes it easy to keep track of our patients history, medical problems, drug allergies, screening tests, important social history and other information. I found that not only was it gratifying for us and the patient to have this information organized and immediately accessible, but that it was simply good medicine. Now, when I go into a room, not only do I know the name of the patient, but also the names of both parents and all siblings. In addition, I also know their medical problems, drug allergies, immunization status and what the parents do for a living. All this information is gained from a 5 second glance at an organized chart. As a nice finishing touch to a good charting job, interpersonal information such as shared acquaintances and interests are jotted down. However, what I didn't expect when we began writing these things down, was that I would begin to remember them without the chart. You cannot imagine what it does to a doctor, patient relationship to be able to remember a simple thing, such as a patient's first name in an encounter at Wal-Mart.

I find that patients want their doctors to know about them without the doctor having to ask the same questions repeatedly. It is inexcusable to a patient to be asked the same question over and over again during different office visits. I know of a minister from a small Arkansas town who has been asked the name of his profession on each of his last five visits with his doctor. It is no wonder that this man is seeking a new physician. Obviously, his present physician is not even interested enough in him to write down what the man does for a living.

As a physician puts his or her patients first, there are other things that begin to happen in the practice. One of those things is pain control for patients. A "beloved physician" is good at doing procedures and managing illnesses with as little pain as possible. Regional anesthesia, nerve blocks, TAC (Tetracaine, adrenaline, cocaine solution), Versed, EMLA cream, and morphine are words that are in his or her vocabulary. Of course, the physician is skilled at their use and does not let a patient abuse these drugs.

Tears are welcome in the office of a “beloved physician”. Emotion from patients is a natural part of what we do. We should be comfortable with emotion from our patients. When tears are not welcome, it signals a problem with the doctor, patient relationship. A patient’s comfort in the office is given priority. A “beloved physician’s” office is designed to provide comfort and privacy. A patient’s dignity is never trampled by the routineness that we feel in doing genital exams or our hectic schedules. As much as possible, we should respect the value of our patient’s time and try to minimize their waiting times. We should be patient as we examine people. I find that if I have patience with a child during an examination, explaining what I am about to do beforehand and then retreating if the child feels that I have advanced too fast, that even very small infants will accept my examination without crying. Over time, the practice is filled with children who actually enjoy coming to the doctor. Examinations take less time because we are not trying to examine a screaming child. The “beloved physician” should be concerned about not overburdening his or her patients financially. “How much will this cost my patient”, is a question we should ask often. Sample medications are sought and given in situations where they will do the most good, such as with self pay patients. There are some situations in which we need to write “no charge” across the top of superbill. Attention to such details endears a physician to people.

This past week I took a chart out of the door rack and noticed that it was the chart of a two year child whose family had moved to Dallas, Texas six months previously. During her last visit, I had wished the mother well and told her to send me Christmas cards of her child as she grew up. On this visit, I thought that they were probably in Little Rock to see relatives and that the child had become ill. I was mistaken. They had driven from Dallas to see me. The mother explained that her child had experienced two seizures associated with fever. They were brief, but very frightening to her. The doctors in Dallas had done a thorough work up. The child had a MRI of the head along with an electroencephalogram (EEG). The pediatrician and pediatric neurologist had concurred that these were harmless febrile seizures and that no treatment was needed at present. They told her treatment would be needed only if more seizures occurred without the presence of fever and that the treatment would be with an anticonvulsant which might lower her child’s I.Q. slightly. The mother believed that the information given to her was all correct.

What was fascinating to me about her visit, was that she wanted to hear me tell her the same information, but with one difference. She wanted the information filtered through a doctor that cared about her and her child. You know, sometimes, the same information sounds very different when it is filtered this way. No, for you melancholics, this lady did not have a codependent type personality. She is rock stable. However, in a time that was very frightening for her, she needed something that she did not get in Dallas. She needed for her physician to care.

For me, my style is that usually I will not be kissing my patients on the head. That is not my personality. However, I do try to give something of myself to every patient that I care for. You see, being a “beloved physician” is a choice we make every day, every time we go into a patient’s room. That choice is about putting our patients first and doing what is best for them even if they do not know it at the time. It is about acquiring knowledge and technical expertise, because these things help our patients. It is about being up to date and giving our patients top notch medical care with a spirit of excellence every time we see them. But more than anything, being a “beloved physician” is about caring. It is about demonstrating that care in a genuine way that matches who we are. It is about meeting our patients’ needs. When we invest in the lives of others, with that investment comes rewards. Some of those rewards are the reciprocal care and concern of our patients. When we have patients that we as physicians really care about, then and only then, will we begin to know what it is like to be a “beloved physician”.