Pearl

Scott Conley, M.D.
Lancaster General Health Physicians Family Medicine Norlanco

"I think I have diagnosed myself this time," proudly reported the 80-year-old widow sitting across from me in the exam room. Pearl was a kind, yet frail, soft-spoken woman with short-cropped gray hair, narrow glasses, and a face that reminded me of an owl's. Curiously, she became my patient only after she was widowed, even though she would often accompany her husband to his visits with me. I was the favorite doctor of her husband, a retired dentist. That this man—a fastidious thinker with a keen grasp of medicine—preferred me as his doctor made me most proud. After his passing, Pearl brought me a pair of his cufflinks. I don't wear cufflinks but I knew what the gift meant.

Pearl continued that she had felt something strange "down there" for a few weeks, and, after overhearing two women talking at church one Sunday about falling bladders, consulted her Merck Manual and confirmed she must have one too.

My first mistake was running with her diagnosis before examining her myself. After a few brief questions, I drew a quick diagram showing her how a female bladder drops. I thought it strange she would have a prolapse after recalling her nulliparity, but I quickly dismissed the thought in my haste to move onto the exam.

Once Pearl was settled on the exam table and my nurse had adjusted the requested pillow to her liking, I asked the widow to spread her legs. Immediately I knew her diagnosis was wrong. An angry, fungating mass had replaced her left labia. I recoiled, shocked at the appearance, repulsed by the odor, and stunned by the implications. But the worst part, and my second mistake, was that Pearl had seen my reaction. "I don't like that look on your face," she stated nervously. Though she was lying down, her head was elevated just high enough to be in my line of sight. Darn pillow.

Feeling her stare, but avoiding eye contact, I did my best to unfurrow my brow and exclaim with a forced smile, "Oh no, I am just trying to figure out what's going on here, just checking out . . . just trying to see if your bladder is dropping . . ." My performance wasn't very convincing.

Is there a worse feeling than stumbling upon something bad in front of a patient? One afternoon years ago, I stood in front of a light box examining the chest X-ray of a 24-year-old male who sat nearby. The radiology tech could have given me a heads up on what I was about to see, but she didn't. Numerous rounded white densities pocked the normally black lung voids. I caught myself before I cursed out loud, remembering that the new cancer victim was staring at me from 15 feet away.

As my heart sank deep into a gastric fold, I realized I would need to somehow hold myself together in front of Pearl and project a calm demeanor. I didn't know *for sure* it was cancer (even though the alarms going off in my head seemed loud enough to be audible), and I didn't want to drop a bomb of a diagnosis on her all at once. So I poker-faced it, stumbling through words of vague reassurance while discreetly wiping the sweat off my forehead.

The rest of the visit with the fragile octogenarian was as much of a blur for me as I'm sure it was for her. But there was no hiding my suspicions after informing her that we had arranged an appointment with a nearby specialist, a gynecological oncologist. "Do you think it's cancer?" she finally marshaled the courage to ask after several minutes. My usual response to this question seemed inadequate: "We don't know for sure until a biopsy is done, and it could turn out to be nothing, but I am concerned."

The squamous cell carcinoma took Pearl's life 15 months later.

Years of practicing medicine grinds us down as physicians. Hundreds if not thousands of patient interactions inevitably erode our edges. But it turns out we like the smooth exterior this creates; it makes us feel established, efficient, even aerodynamic. We glide through our workdays, performing examinations without thinking, navigating insufflated colons like we're driving in our neighborhood, reciting speeches refined

through years of repetition, always seeking the least resistance possible. Yet this gives our patients nothing to hold on to. We can easily slip through their fingers and out the exam room door, leaving them with nothing but an anemic After Visit Summary and a hefty co-pay.

The visit with Pearl made me stutter and perspire. It was sharp and shocking. And yet the experience made me feel . . . more human. My emotions tracked with hers. I was as broadsided and concussed by the findings as she was. I shared the same pit-of-the-stomach sensation as her fallen countenance led me to believe she was feeling. And in that moment, I had edges again. The shared emotion created handholds for the elderly widow to grasp as the ground was giving out beneath her. My genuine and raw empathy welded a deep connection between us. She could look into my eyes and see herself but in different skin. I felt authentic again.

Now, certainly, one of the critical lessons to learn in medicine is self-preservation. A physician cannot get too emotionally involved in every case. Burnout would be swift and debilitating. We need to pace ourselves for the long haul. Yet too often we err on the side of emotional indifference. With all the complexities of modern medicine, with all the administrative tonnage on our backs, with the endless line of needy patients at our door, it's easy to misplace our empathy. And yet empathy is the most organic instrument in our doctor bag. It's the one thing even the most futuristic medical technology will never be able to reproduce. And while emotionally exhausting, I periodically need moments like Pearl's visit to defibrillate my heart back into its proper state.

The greater challenge, though, is not necessarily learning from these shocking moments when they occur, but rather maintaining empathy when they do not. When my week is full of follow-ups and insurance forms, what can I use to nourish my empathy? Referring to a patient by name, rather than as "the diabetic in Room 3," is a good start. Carving out brief moments for small talk with patients helps as well. Practicing my skills in identifying and responding to empathetic opportunities* during office visits works too.

Pearl's visit was hard, but it was also easy; empathy flowed freely. For all my other encounters with patients, the true art of medicine is found when I remember what it feels like to be the human at the other end of the stethoscope.

* For an excellent description of empathic opportunities see: Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA*. 1997; 277(8):678-682.

Scott Conley, M.D.
Family Physician
LGHP Family Medicine Norlanco
418 Cloverleaf Road
Elizabethtown, PA 17022
717-653-1467
scconley@lghealth.org