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Editorial

Road Rage in the Doctor's Office

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Editorial

A man appears in my office. Distinguished looking, a CEO, in his early 70's. He is here because he has minor, intermittent knee pain. His exam and XR's are consistent with early osteoarthritis. I suggest that he take an anti-inflammatory medication such as Motrin when needed. He tells me that Motrin works well and he has no problem tolerating it, but that he doesn't intend to take pills for the rest of his life. He says he wants to have his knee fixed. When I realize that he is talking about a total joint replacement, I suggest that this is perhaps premature, considering how well he is functioning, and that even if the surgery goes smoothly, a joint replacement is never as good as one's own knee. I repeat that surgery is perhaps not the appropriate treatment for the minor symptoms that he is having. He repeats that he wants his knee fixed. He insists on a second opinion.

What is wrong with this picture? Or this one

An engineer in his forties comes in with his daughter. She is 16 years old and has a significantly displaced clavicle fracture. He tells me she has to get back to soccer – there's an important tournament coming up and she's needed on the team. I tell him she's not ready – it's only four weeks after the injury, she's still feeling pain, the fracture isn't healed yet, there's no callous (new bone) on XR, and a re-injury could be very serious, possibly harming the brachial plexus and major blood vessels. He insists that she's needed on the soccer field. I repeat, she's not ready and that I'm not willing to sign the release form indicating that she's well enough to play sports. "I want to know what the stress-strain curve of the bone at four weeks is compared to twelve weeks", he demands of me. He is hurling terms at me from his field, from engineering, that have absolutely no practical bearing on the situation. I still refuse to sign. He insists on a second opinion.

(I do sign such release forms occasionally, with the qualification 'against medical advice,' meaning that any consequences that result are the patient's responsibility. However, it was not reasonable to sign the form in this case due to the seriousness of the potential complications)

Another scenario

A 40-year-old man comes to my office, complaining of knee pain. I take a history, perform an exam, and tell him it's a common knee problem known as patella-femoral syndrome. I recommend physical therapy, bicycling and anti-inflammatory medication to start. He demands an operation. I tell him that unfortunately there is not surgical procedure that will cure his problem. "I have a friend," he says, "who had pain like this and he had this operation and now he's better." I tell him that an arthroscopy is helpful for certain types of knee problems, but not the particular problem that he has. He repeats, he wants the operation his friend had. I repeat that surgery may have serious complications and would not be appropriate unless it was likely to fix his knee problem. He repeats that he wants an operation. I am the enemy; we are locked in mortal combat. (He gets a second opinion, and an operation – and a major potentially life-threatening complication – a pulmonary embolus)

What is wrong with these interactions? How do I begin to unravel the dangerous misconceptions and assumptions, the unrealistic expectations that patients bring to their medical situations? – expectations that make their diagnosis more vexing and problematic.

There are the totally unrealistic expectations about surgery – that it will fix anything, that it has no risk. There is a denial, strong in us all, and the expectation that everything in our body is replaceable/our bodies consist of totally replaceable parts, even though they themselves may be fairly advanced in age. Yes, medical science can do wonders, and a joint replacement may be transformative, but there are certain limits that a given body or injury or situation imposes that cannot be altered—some things for which there is no replacement, some fractures that will leave a

limp, some syndromes that are chronic in nature, some conditions that are irreparable and going to get worse with age.

When I suggest there are things that cannot be fixed, patients react as though I am withholding some magical treatment from them that they're entitled to.

Through it all, underlying all patient-physician interactions, is the unwritten code – The patient is always right –partly because he/she is vulnerable, and partly because he/she is a consumer – and can do no wrong, and should not be challenged. (This has evolved in this consumerist age into the assumption that the customer is always right.) Also underlying our interactions is the threat of litigation. If patients don't get a perfect result, they feel entitled to sue, even though the risks are explained thoroughly in advance, even though a predictable complication from a standard procedure cannot be construed as malpractice.

I am amazed at the sense of entitlement. I am amazed at the suddenness and frequency with which such situations escalate into rudeness and anger. Always there is the assumption that I should remain cool, calm, and collected, unfailing in my compassion – they are not nice, but I am to be nice at all times; after all, I have no feelings, I am the doctor. Why do doctors become cold and insensitive? I wonder, feeling myself cringing from this steady stream of abuse.

It often seems, the nicer I am, the warmer and engaging, the heftier the dose of rudeness I get in return. I wonder, do these things happen to me more because I am a woman? "Hi, I'm Dr. Ratner" I say, introducing myself to a patient' "well, Vicki, let me tell you about my knee." This is so common an occurrence that I have had my first name removed from my name tag, but the notices sent in advance to the patients confirming their appointments have my full name, so 'Vicki' I remain. Do my male colleagues get such a hefty dose? Probably not. I have found, however, that the more 'authoritative' I am, the fewer options I offer, the less likely the patient is to become angry. The more time I take to explain a medical problem, the more options I offer as well as the one I recommend and why I recommend it, I am then labeled 'indecisive'. Again, a possible consequence of gender.

I wonder, do these things happen to me more often because I work at an HMO? Do physicians in private practice encounter as much rudeness? Probably not –they have the option of referring such patients out of their offices. We have no such luxury. Does it have to do with the type of patient I'm dealing with – a population that includes a high proportion of professionals in Silicon Valley, California: CEO's, engineers, executives? But the sense of entitlement of the population at large seems to be increasing, related perhaps to consumerism. Health care is becoming, has become, a commodity. This is an increasing trend in clinical medicine.

I'm well aware of the other side of this argument – in fact, I've often been on the other side of the argument. I'm the founder and president emeritus of the Interstitial Cystitis Association, a grassroots organization that has promoted public awareness, patient education, and research into a little-known bladder condition that I happen to have. I have, with my own medical condition, faced many incompetent/insensitive doctors/ limited in their scope of knowledge, in private practice who've told me my problem was 'all in my head', who did not bother to order the tests necessary to make the diagnosis. In fact, there's a certain irony in my taking this position, since I have worked as a champion of patients' rights for nearly 30 years, urging patients to stand up for themselves, make doctors accountable, seek second opinions.

But physicians have rights too – the right to be respected as human beings, to expect a little civility. The right to be listened to. Surely it means something that I am the doctor – we do have some training and education that makes physician-patient dialogue more than a matter of opinion. Yes, patients should stand up for their rights, but the patient is not always right. Often the doctor is right and it's not a matter of opinion. Patients do have to trust, that the doctor may (occasionally) know better --- because an operation made their friend's knee pain go away, it won't necessarily cure theirs: pain can be caused by many different things. Besides, rights imply responsibilities. With the Internet, patients have access to enormous amounts of information. Patients should ask questions and bring information to their doctors for review, and insist that their opinion be taken seriously, but they should also behave in a mature, civil way and not indulge in 'regressive acting out', making the physician into a magical dispenser of cures on the one hand, or an object to be reviled on the other.

My point is not just that these people ruin my day, which they do, but that this sort of interaction/this dynamic creates an unfortunate situation that works to no one's advantage. It gives new meaning to the term defensive medicine – it's not just that we're ordering tests and operations to protect ourselves from lawsuits; it's that the patient's pressure puts us in an adversarial relationship which requires more attending to than the diagnostic problem at hand. It goes without saying that it also drives up the costs.

I'm well aware of the kinds of criticisms these observations open me to. I'm aware that in saying such things, I'm breaking a taboo, the strong unwritten code that the patient is not to be challenged – that he or she is somehow too fragile and vulnerable. In saying this, I'm making myself vulnerable. That's why you may hear physicians discuss these issues among themselves, but few would choose to go public with it. But to keep this silence only perpetuates an unhealthy situation.

Patients should not act out their road rage on their doctors.

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