

# A Good Physician — On Complacency and Communication

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In the fall of 1997, my medical school roommate lent me her copy of Anne Fadiman's *The Spirit Catches You and You Fall Down*.<sup>1</sup> I stayed awake for two nights, fascinated and appalled by the misunderstanding between the young Hmong patient's family and her American physicians. Taking the cautionary tale to heart, I dutifully used the triangular seating arrangement recommended for patient, interpreter, and physician. Often before the interpreter could translate a response, I knew whether the patient was confused, unconvinced, or frightened, and I delighted in the power of this connection.

But much can change in two decades. I recently cared for a 45-year-old man for over a month and never spoke to him. He was admitted with cardiogenic shock, stabilized, and listed for heart transplantation. Every morning, I rounded with my heart failure team. The patient, pulmonary artery catheter secured to his neck, usually looked up when we entered but then returned his attention immediately to his ever-present phone.

His father was the other constant in the room. Every morning, as I spoke to his father, I glanced at my patient. He would offer a half-hearted smile, but I never knew how much he understood or what he was thinking. I sometimes asked the cardiology fellow to circle back after rounds to see whether the patient had any questions, but I never asked

for updates and never went back myself.

After a few months, the patient received the magic call. He sailed through transplantation and was home within 10 days. I should have been proud, but an

recite the names and dosages of his medications by heart. His father appeared relieved to no longer be our go-between, and I was ashamed because I had never bothered to learn more than the patient's medical history.

He had had a myocardial infarction in his early 40s, which was complicated by ventricular septal rupture. After surgery, he was left with an ischemic cardiomyopathy, and 2 years later, consideration of a transplant was warranted. His condition was stabilized with low-dose inotropic support, and I planned to discharge him to wait for a heart transplant as an outpatient. But his insurance company decided that though they would approve transplantation, they would not approve a defibrillator. How could he go home with inotropic support but no defibrillator? Alternatively, how could he be listed as an outpatient with a projected wait time of months to years, yet remain in the hospital?

He spent 2 weeks in limbo, and every day I explained to the father his son's uncertain future. I described my attempts to corner the insurance company's medical director across time zones and his seemingly conscious efforts to duck my calls. I offered the option of a wearable defibrillator, and when the insurance company also declined to pay for that, I described our (also unsuccessful) attempts to finagle a free device.



adage from William Osler nagged at me: "The good physician treats the disease; the great physician treats the patient who has the disease." I knew I had missed the mark.

At the patient's first visit to the heart transplant clinic after surgery, we had our first conversation. I perched on the exam-room stool, one point of a triangle with the patient and the American Sign Language (ASL) interpreter, and introduced myself. As the interpreter's hands fluttered like birds, I was equally charmed and embarrassed.

My patient had a bright and ready smile. He joked about his low pain tolerance but still tried to avoid pain medications. He was excited because he could climb a flight of stairs. He was proud to

The patient's body ultimately made the decision for us. His creatinine level, the canary-in-the-coal-mine of organ perfusion, worsened, and he required higher doses of inotropic support that justified listing him as an inpatient. The uncertainty about how to safely usher him to transplantation was resolved. Throughout it all, his father was calm, while my patient's face, lit only by the glow of his phone, remained inscrutable. Whenever I care for a patient in the hospital awaiting a transplant, I always ask, "Is there anything we can do to make your life easier?" But I never asked him.

Why had I settled for being just a good physician? Half the problem was logistics: scheduling a daily real-life ASL interpreter, available in the 2-hour window allotted for teaching rounds, seemed impossible. The other half was the absurdity of a video interpreter: between the fuzzy screen, the static-filled audio, and the time delay, any conversation would have left us more confused and frustrated than when we started.

In retrospect, I should have used his father as interpreter instead of messenger. But on my first day, neither the patient nor his father requested that I speak directly with the patient, and after the second and third days passed with the same calm acceptance, we fell into an easy

(for me) inertia. I was relieved to avoid explaining the same frustrating medical quandary twice each morning. I fell into a complacency born of pragmatism and confidence in my abilities: I knew I was providing the best medical care, so I ignored the importance of direct communication.

In the two decades since I finished medical school, medical dilemmas have ceased to keep me up at night; there is rarely a situation I have not encountered already. But after that clinic visit, I did lose sleep. How had my patient felt, being ignored each morning? How frustrated was he, a grown man, made to rely on his father to understand his own care? And what if his condition had worsened, warranting discussions of mechanical circulatory support or hospice? I had neglected to gain the trust that is essential for guiding patients through difficult decisions. When presented with the unique challenge of caring for a deaf patient, I took the convenient way out, every day, for a month. I'd set a poor example for my team, I'd failed to comfort a patient in need, and I'd missed out on the joy of that relationship.

On his second clinic visit, I worked up the courage to apologize. He was nonplussed yet gracious, my negligence but a blip

on the radar of his new life. He was also resigned, explaining that he had stared at his phone because trying to follow spoken conversation was too frustrating. After the third visit, I emphatically signed "You're awesome," realizing a few months too late that nuances of tone and style could be conveyed without a voice.

I never returned my roommate's copy of *The Spirit Catches You and You Fall Down*, and Fadiman's words now offer an ironic reminder and reproach: "Every illness is not a set of pathologies but a personal story."<sup>1</sup> My patient had a happy ending and he has forgiven me, but that is beside the point. It is harder to forgive myself. I suspect I will always feel a prickle of guilt and embarrassment when I see him, and that small sting will remind me of something I will not forget again: diseases may become routine with experience, but patients must not.

Disclosure forms provided by the author are available at [NEJM.org](http://NEJM.org).

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1. Fadiman A. *The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus and Giroux, 1997.

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