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What if...?

Survival Guide for Physicians

What if . . .

Survival Guide for Physicians

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This book is dedicated to

My wonderful wife, Karen; my editors, Andy McPhee and Brenna Mayer; and my co-author, Bruce. Their patience and invaluable help made it possible to complete this book. **R.G.**

My family, including my younger brother Tom, who left us far too soon; my close friends, who have stood by me through thick and thin; our editors, Andy and Brenna; and my co-author Ron—all of whom made it possible to complete this book. **B.L.**

Preface

Despite rigorous medical education and training, are medical students, residents, and physicians equipped to handle all the situations they may face? Over the course of our careers as practicing physicians, administrators, and educators, we've encountered a remarkable number of scenarios not covered by formal medical education and training. Some are common and others are unusual. Some are life-threatening and others aren't. However, all are important and potentially challenging. Whenever these scenarios occur, people usually assume that you can and will handle them—just because you are or will be a physician!

Through our book *What If...? Survival Guide for Physicians* we hope to fill some of these gaps in education and training and help physicians and students of all levels feel better prepared to handle whatever comes their way. Each entry in our book is similarly structured and presented, with sections on what to do in a given scenario and possible measures you can take to prepare for it or prevent it from happening. This structure makes it easy to absorb the straightforward, step-by-step instructions and tips on dealing with a variety of crises, such as:

- *What if a patient has a cockroach or similar insect in her ear canal?*
- *What if you have to deliver a baby outside the hospital?*
- *What if a patient threatens your life?*

There are also entries on less dangerous and more common situations for students, residents, and practitioners, such as:

- *What if you feel faint at the bedside or in the operating room?*
- *What if you have been up too many hours and are having trouble thinking?*
- *What if you think a patient is faking?*

Physicians at all levels, especially residents and medical students, typically have a driving need to feel knowledgeable and in control—even when their insides are swirling. This book can provide valuable tidbits of information that others around you may not know. Having such knowledge is empowering and fulfilling, and will help you become a confident, respected, and important source of information and experience to others. So, dive in and take your knowledge to another level!

Ronald B. Goodspeed
Bruce Y. Lee

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What if . . .

A patient or patient's family thinks you're a real doctor?

So, someone thinks you're a real doctor. After years of premedical and preclinical study, you probably think it feels good when someone calls you a doctor, listens to your clinical opinion, and depends on you. Think again.

Being a doctor carries a lot of responsibility. Will you be available on weekends or after hours? Are you prepared to take the blame if anything goes wrong, even if you weren't the cause? Can you answer all of the patient's questions? Can you take care of a life-threatening emergency? Are you prepared to deal with a patient who's angry, upset, delirious, or even violent? If the patient needs something, can you deliver it? Will you even be able to recognize when you're doing something wrong?

There are huge risks involved in pretending to be a doctor. You can injure or even kill a patient. You can hurt yourself physically and professionally. Without experience, you won't know what precautions to take or how to recognize dangerous situations. Even if no significant problems occur, if someone discovers your masquerade—and someone *will* discover it—you could fail your course and suffer significant disciplinary action. How will you be discovered? A patient might ask her nurse, physical therapist, or physician for you. When she's discharged from the hospital, she may ask for your office number or try to contact

you later. There is a good chance that your advice to the patient will disagree with that of others. Even full-fledged physicians commonly disagree in their opinions. When these conflicts emerge, your team will soon realize the source of the conflicting advice.

Obviously, being a physician has its rewards. Why else would so many people go through all that training? However, until you're qualified and ready to handle the responsibilities and aggravations of a physician, you can't truly reap the rewards without problems quickly overpowering everything. So it's best not to pretend to be a doctor. You'll have plenty of time to be a real doctor in the future, and there are days when physicians long to be relatively responsibility-free medical students. So why rush it? Enjoy being a medical student while you can.

In fact, being a medical student has other advantages. You have time to focus on a few patients, listen to their concerns, provide emotional support, and identify clues and problems that the busy residents and attendings may miss. You don't need to be a full-fledged doctor to have an impact and earn the respect of patients.

What To Do

If someone mistakes you for a doctor, remind her that you're a medical student but feel free to explain what you can do for her. Take advantage of your status as a medical student. Show how important you can be. Be the patient's advocate. Promptly alert nurses and your team when the patient has a new medical problem. Spend time listening to your patient and her family. You can be an essential information source for your patient and your team.

CLINICAL SNAPSHOT

Dangerous deception

As a medical student, you've been seeing a patient and his family every day for almost a week. Through hard work and attentiveness, you've built a rapport with them. One problem, though—they think you're his doctor. So, what happens if one day the patient starts having some chest pain? Can you tell if he's having a heart attack, angina, heart burn, pericarditis, an aortic dissection, or a panic attack? Do you know how to handle each of these problems?

The patient and his family will expect their "real doctor" to know what is going on and what to do. They'll be worried and may shower you with questions while you're trying to determine what to do. Do you try to handle the situation and risk seriously injuring or even killing the patient? Or do you get a "real doctor" to help and risk exposing your deception to the patient and his family and losing their trust? Don't get into this lose-lose situation. Don't pretend to be a doctor.

(Of course, make sure you know what you're talking about and don't mislead anyone.) Ask your residents and attending physicians how you can help your patient. Ask your patient and her family how you can help them. You'll be surprised at how much you can do. If you're honest, helpful, and attentive, patients and their families will depend on and respect you—everything that playing a doctor may have brought, but without all the dangers and hassles.

Prevention and Preparation

To avoid confusion about your role in a patient's health care, clearly introduce yourself as a medical student to the patient and her family. (Many times the attending or residents will do this for you.) Explain that, while you aren't yet a "real doctor," you're part of the team that is taking care of the patient and can serve as a liaison between the patient and the team. Be there when the patient needs something explained, has a concern, or needs comforting. You and the patient will soon learn how valuable a medical student can be.

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What if . . .

You feel faint at the bedside or in the operating room?

Fainting, or *syncope,* is a common occurrence for first-time observers of procedures in the operating room (OR) or at the bedside. Feeling faint is the sensation of an impending loss of consciousness, characterized by feeling weak. Vision may be blurred, dim, or speckled with black spots. You may also experience *tinnitus.* If these symptoms are allowed to progress, a syncopal episode will ensue.

Syncope in a young healthy person is generally due to a transient decrease in blood pressure and subsequently diminished cerebral blood flow when sitting or standing. In a novice who's extremely worried about fainting or is experiencing severe emotional stress, vagus nerve activity can increase. This increased vagal activity can lead to bradycardia, accompanied by venous pooling in the lower extremities and hypotension, which commonly results in syncope. Fainting can be highly embarrassing and unpleasant. It also carries the potential for injury from falling—or injury to patients from falling on them!

What To Do

As soon as you start to feel faint, begin flexing and relaxing your leg muscles to enhance venous return to the heart. If you can, step away from the patient. Then

try to squat down as promptly and tactfully as you can. The squat maneuver increases the venous return of blood to the heart, causing an override of the vagal activity and increasing your blood pressure and cerebral blood flow.

Depending on the circumstances, it may be more tactful to drop something on the floor, such as a pencil or an instrument, and then squat to pick it up. You might also squat to retie your shoelaces or straighten out your stockings or pant cuffs. Stay squatted as long as you can. Upon assuming the upright position, begin flexing and relaxing your leg muscles again. On rare occasions, the squat maneuver is inadequate but it may provide enough relief to excuse yourself from the room.

If you're gloved and "sterile," picking up things from the floor or tying your shoes isn't the best option. In that case, while flexing and relaxing your leg muscles, focus on the procedure you're observing. Imagine you're actually doing the procedure and try to anticipate the surgeon's next move.

WARNING!!! Don't delay! At the first symptom, start your maneuvers to stop the vasovagal syncope cycle! Your safety and that of the patient is of the utmost importance. So, if your condition doesn't rapidly improve, set embarrassment aside and leave the room. Then lie down for a few minutes until you feel better. Although the recumbent position is the most effective treatment, it isn't as easily accomplished without excusing yourself from the procedure in progress.

Prevention and Preparation

Knowing what to do if you feel faint may be all you need to prevent it. Knowing that you can handle this situation if it develops is nearly always sufficient to prevent you from experiencing it. In addition, always make sure you're well hydrated and try not to begin the procedure on an empty stomach. Remember, now that you've read this *What if* scenario, you probably won't ever have this problem!

What if . . .

The first patient you're assigned to examine refuses?

You're about to examine your first real patient; your white coat is on, stethoscope somewhere on your body, and the history and physical script in your memory. Then, your first true foray into clinical medicine is derailed . . .

There are many reasons a patient may not allow you to examine her. The patient may not want to be seen by anyone other than the regular physician. Perhaps the patient wants to follow up on a previous conversation or discuss sensitive, confidential information. Commonly, patients don't want to spend time speaking to someone new, as they're late for a subsequent appointment, not in the appropriate mood, or suffering discomfort. Some patients associate being seen by a "trainee" or "student" with being used as a "teaching tool" or an "experimental subject."

Many patients also have their preferences and prejudices; so, unfortunately, some may be biased against you. In the eyes of the patient, you may not have the right appearance, race, or gender or be of the "right" age or physique. There are some situations in which such biases may be more prevalent. For example, male medical students may have more difficulty with female urology patients or gynecology patients and students of Vietnamese descent may have more difficulty with some Vietnam War veterans.

Finally, because many patients are distracted, confused, or hearing impaired, they may misunderstand what you would like to do. Patients have refused because they thought medical students wanted to give them a written test ("examine"), take them to surgery, give them an enema, change their bed sheets, take away their dinner plate, give them medications, switch their rooms, or change their bandages. Remember, many hospitalized patients see a constant stream of physicians, nurses, physical therapists, hospital representatives, phlebotomists, and technologists. It can be difficult for them to keep track of who does what.

Ultimately, because patients are under no obligation to permit medical students to talk to or examine them, it's their prerogative to refuse at any moment. Fortunately, for medical education, there are plenty of patients willing to help students.

What To Do

Don't take the refusal personally. Even if the patient is clearly biased against you, realize that the patient doesn't know you at all and her judgment may be impaired by illness or ignorance. Remain polite, thank the patient for her time, and leave the room. If you suspect that the patient is misunderstanding your request, you may politely ask again, explaining more carefully who you are and what you plan to do.

Remember, there will be plenty of other patients for you to examine, so finding another patient should be no problem. Don't let patient refusals affect your confidence. Be honest with your instructor. Because patient refusals happen all the time, it should in no way affect your grade or your instructor's impression of you.

Prevention and Preparation

If you find that many patients refuse your examination, perform an honest self-assessment. Consider asking friends to observe or videotape you. There are some things you can do to improve your chances of patients agreeing to your examination.

Come Clean

Make sure you and your clothes are clean. It will not only help you with patients, but potentially dramatically improve your social life.

Wearing Out Your Welcome

Patients may find certain articles of clothing and accessories too revealing or too off-beat. While wearing such items may express your individuality, an often important and worthwhile goal, unfortunately, it may also cost you patient acceptance. Ultimately, if you're wearing anything that patients may find unusual, you'll have to weigh the costs and benefits and decide whether it's worth dressing more conservatively for patient interviews.

Express Yourself . . . Appropriately

Patients may be disturbed, concerned, or even frightened by extreme expressions, such as those that make you look angry, bored, sad, or constipated. An appropriate smile can help, but excessive grinning like a Cheshire cat can make you appear disingenuous or slightly crazed. Be aware of what your eyes and body may be doing. Avoid rolling your eyes, finger tapping, winking, or any other movement that makes you look impatient or disdainful. Modulate your voice. Some students speak too softly, whereas others speak too loudly. Be careful about standing too close to or too far away from the patient.

Say What?

Be careful about what you say when you first meet the patient. Address the patient respectfully. It's safer to use appropriate titles, such as Mr., Mrs., or Ms., with the patient's last name rather than the patient's first name. Clearly introduce yourself and explain what you would like to do.

Timing Is Everything

Finally, don't choose times during which the patient is more likely to refuse an examination, such as when she's sleeping, meeting with visitors, eating, or sitting on the toilet. If you see that the patient is busy, consider returning when the patient is more available. After all, how would you feel if you were sitting on the toilet and someone walked in wanting to interview you?