# Common Dilemmas in Practicing Medicine, Part 3
## Parting is Such Sweet Sorrow

*by:*
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When I started work as a clinical social worker in Group Health's Mental Health Service in August 1976, I was assigned for part of my orientation to the Mental Health Service's Entry Unit, where all the telephone intake (and a good deal of informal psychotherapy) took place. I was listening in on the phone calls of Mental Health Specialist Joan Morris when a hypomanic patient called. The patient talked uninterrupted for five minutes straight, and then Joan said, firmly but not unkindly, and without apparent guilt: "I'm going to ask you to stop talking now." The patient, surprised, immediately complied and they were able, with considerable further direction from Joan, to get down to the business of the patient's reason for calling that day. I realized that Joan's main goal was not to avoid the patient's anger, but to move ahead with the business of the phone call. Over the next few years I began to feel quite comfortable with saying "our time is up for today" to my patients.

A couple of years later, when Dick Tinker asked me to join the Faculty of the Family Practice Residency, I was amazed when I started following residents around in their clinics to discover that none of them ever said "our time is up." I was very naive about family medicine in those days, and did not realize that the time is never really up, because all manner of patient concerns are considered to be within the province of the family doc. I quickly learned what a difficult profession medicine is. The title of this article, "parting is such sweet sorrow", honors the fact that not only the patient, but often the physician too, would like more time—and yet to spend that extra time seems less and less possible in today's medical practice.

As part of the survey of Group Health physicians I did a couple of years ago, I asked the question, "How do you say good-bye and leave the room, particularly when it appears that the patient wants to spend more time with you when his/her concerns are still unresolved?" As with my earlier two questions (see Common Dilemmas in Practicing Medicine, Parts I and II, this journal), the variety and scope of answers of the hundred respondents were fascinating.

In mental health practice, a common maxim is "resistance before content." That is, one should discuss the difficulties in talking about something before talking about the item itself. What comprises physician resistance or reluctance to leaving the room? In your answers to this questionnaire, and in the practice management consultations I have done over the years, I have sensed a number of factors involved: (1) many patients and physicians do not feel the time is up until all the presenting concerns are addressed; (2) for the physician, a tremendous amount of internal discipline is required to structure each patient visit for maximum efficiency: visit after visit, day after day, never "letting down"; (3) patients generally wait a fair amount of time to see the physician, so it can feel to the physician that he or she cannot cut the visit short with a patient who has already been waiting; (4) the organizational skills of the provider are challenged enormously by multiple problem patients (remember those prescriptions, that specialty referral, the lab work, that pamphlet you said you'd provide, etc.); (5) unacknowledged guilt on the part of the provider can make it difficult to leave the room, particularly with a patient who is still "wanting something." Avoiding patient anger can be a goal for many physicians.

A final factor has come up in recent discussions I have had with physicians: many feel that when they are in the corridor or in their offices, they are constantly being interrupted with multiple competing demands, and that the only "safe time" is in the exam room with the patient, where focusing on the interaction and the patient's problems can feel comfortable and satisfying! As one respondent said, "lots of people want to continue to talk, not the least of which is me!"

Many respondents to my questionnaire said that they tended not to leave, but rather to stay in the room until they and the patient come to some resolution on most major issues. If the patient's concerns are unresolved, one physician noted, "I know I will have to spend more time either on the phone or at another visit anyway. I'd rather stay in the room and be late." Of course, this solution becomes less tenable as workload increases.

The answers offered to this question are a mirror for what actually goes on in the last few minutes of the medical consultation. When you are able to leave the room, at least with some patients, the methods of wrapping up the consultation fell into nine categories:

(1) PREVENTION BY EARLY INTERVENTION: Several physicians noted that "I make the list before I examine the patient, so there are no surprises, eliciting, is there anything more or anything else you want to cover today?" Many use this tactic especially near the beginning of a well visit. The time spent early in the visit eliciting as many concerns as possible is well worth it. One family physician, with patients who have a sense of humor, will walk to the door and put his hand on the knob, and ask, smiling, "when I put my hand on the door knob, do you think of anything else you want to be sure to cover today?"

(2) DIRECT ACTION: This is a variant of the technique with which I started this paper, and is difficult for many providers to allow themselves because of the fear that the patient will feel rejected or will become angry. Many say "I have to leave now," or "I need to go now." Some mention "in fairness to the other patients waiting to be seen, we must stop for today." Others acknowledge the conflicting agendas, by stating quite directly that they are aware that the patient needs more time, but that they cannot stay any longer. It is always possible to say, "this might be upsetting to you because you have more to discuss with me, but I must stop for today," or "it's hard to stop when you are upset, but our time is up."

(3) APOLOGY: Many Group Health physicians routinely start their consultations when they are running behind by apologizing for being late. It causes personal stress to feel you are apologizing all day! Nevertheless, several respondents reported saying, "I'm sorry we don't have more time today. I realize we did not spend all the time you needed. I am sorry for the time pressure I am under." "Sorry" can mean regretful, not just guilty!

(4) BODY LANGUAGE: Many respondents reported using body language to help them exit. Some swivel their chair to face the door, move to the front of the chair, close the chart, stand, offer a business card or literature, move toward the door, linger a moment, and then mention there are others waiting. One mentioned turning on his beeper. The issue of body language brings up looking at one's watch or having clocks in exam rooms. I strongly recommend both. Being embarrassed to look at one's watch, and not having clocks in exam rooms, both give the message of timelessness. Keeping to a schedule is part of adult life, and even if the patient has waited to see you, there is still a schedule to which you are trying to adhere. Looking at one's watch and commenting on limited time does not necessarily mean that you are rejecting the patient.

(5) REVIEW OF THE SITUATION: One gynecologist ends the interview in this way: "Let me summarize what we've talked about today (I have a written form for this): problem, my tentative diagnosis, and the plan. We'll give the plan 'x' days/ weeks, then come see me. We need to keep things simple. this plan, then we can add to it next time." In order to maximize the time spent with the patients, others do the chart review aloud in the room with the patient at the beginning of the consultation. Part of the review involves seeking affirmation by the patient of the proposal, and perhaps of the desirability of stopping there.

(6) FOLLOW UP PLANS: The advantage of reviewing the plan is that it calls attention to the time interval required to try the plan, and thus to the issue of time. The plan can mean another appointment, a phone call to the nurse, a behavioral change that may take some time, a specialty referral, etc. etc. Always having a next step calls attention to the longevity of the relationship with the patient, and the hope that their symptoms may alleviate and that you will accompany them even if they don't. One physician who practices in an outlying clinic noted: "I always give the patient some idea when our next encounter will occur. I see many patients in the community setting, and can therefore say, 'I'll see you at Fred Meyer, or at the school play', etc. Basically I emphasize my continuing availability in the future."

(7) CLOSED-ENDED DIRECTIVENESS: Another therapeutic maxim is that the shorter-term the therapy is, more active and directive the therapist. So too with med interviews. Many stated that since they know their panel, they can anticipate in advance which people will put them in this position (of needing to end the interview). One says, "I walk rapidly into the room, sometimes remain standing (but being very attentive to them), and try to maintain control of the dialogue leading them back to the main agenda. When a grocery list is given I never say I can only deal with one thing; instead I say go ahead and list the concerns and we will pick the issue we can take care of today. Often if they at least mention them and I give them a summarizing one line answer it satisfies them." In my practice management consultations, when I see physicians who feel the impetus to work up every problem, I often recommend saying to the patient, "thank you for telling me that. Everything I know about you helps me take care of you." This statement can also be used for emotional issues which may have no quick resolution (for example, when the patient announces a divorce). Another physician actually is able to say to a patient who has told him the whole story three times or more, "yes, I know. We have talked about it." The moral of this story is that as long as you care about the patient, and the patient senses it, you can say almost anything.

(8) REFERENCE TO THE SCHEDULE: This tactic is a tric one these days; it's hard to tell someone who has waited, tha others are waiting! But sometimes it is possible to say just that: "I know you have waited, and this isn't very fair, but I'd like not to keep others waiting longer." One physician says, "I can see you

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have further concerns. But my time is limited by needing to see patients every fifteen minutes." Another says that if she thinks she may need to see more time, she may check her schedule right in front of the patient to see if she has the time to spend. This technique has the advantage of reminding the patient that there is a schedule.

(9) USE OF A TEAMWORK APPROACH: If co-management of a practice with team members is your goal, you need not feel alone in approaching the importance of limit-setting with those few patients who take up much of your time. Team members can sometimes spend additional time with patients, or are even asked by some physicians to interrupt the interview by knocking on the door. If there is team meeting time set aside, team members can brainstorm with each other about certain tients who want more time. The feeling of a team and teamwork can help the provider feel less alone with the patient. For this reason too, asking about what other friends, relatives, or providers are offering support and advice about the problem can help.

Wrapping up the "parting" portion of the medical interview means that termination begins at the beginning of the visit, not at the end. The eliciting of the actual reason for coming—"what would you like to get out of this interview today?"—means having the patient's request out on the table. Only then can the physician know whether that request has been addressed. Bringing differences in agendas out into the open can only help in that process: "you are here today at my request so we can discuss your blood pressure medicine: you have several other agenda items we won't have time for. Let's set up another appointment to meet again." Short-hand approaches can work with patients who are well known to you over time. Finally, it may help to remember that for patients who never feel they have enough of you, the feeling of "not enough" began long before they met you, and will continue long after in the context of their lives.❖

Volume 11 Number 1 Winter 1998

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