Lessons for Doctors

Indianapolis Literary Club

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Introduction

> Let us go forth, the tellers of tales, and seize whatever prey the heart long for…..
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> William Butler Yeats

This essay is based on my new book that will be published by the Indiana Historical Society Press in the late spring or early summer of 2023. This book builds on my previous book, *Family Practice Stories*, an oral history of Hoosier family physicians of the mid-20th century. The book celebrates and preserves America's Golden Age of Generalism in medicine through storytelling. My intent was to capture stories told by and about the grassroots founding fathers of family medicine before they were lost forever.

I will read excerpts from this newest book, *What Our Patients Have Taught Us*, for this essay tonight, as I did for an ILC essay a couple of years ago from *Family Practice Stories*. Is delivering a paper based on a published work (or soon to be published) acceptable and consistent with the traditions of the ILC. I think yes; previous members have done so. J.W. Riley is a good example.

This is a book I could not write alone. Although I contributed about 10 percent of the stories to this collection of essays, this work could not be solely from my own professional experience. I needed the contributions of friends and colleagues in the medical profession for this book to be more inclusive and compelling. I believed this book would have to come from a broad cross-section of physicians and other health-care professionals, capturing the breadth and depth of perspectives and experiences that come from our relationships with patients. My colleagues became contributing authors in this endeavor to bring forward their personal stories regarding the ways a specific patient touched their lives or what they learned from that patient about life, career, or themselves. I will only read excerpts tonight from the stories I wrote myself, so the authorship is mine alone.

I chose to only accept stories regarding experiences with an individual patient rather than narratives about what was learned from relationships with patients collectively during a career. I anticipated that stories about a specific patient would be more personal and powerful. I think one will find these stories true to my intent.

Collecting stories from colleagues was not an easy task; physicians and others in the health professions do not generally consider themselves writers, and some even loath authorship. Many are not inclined to imaginative or reflective writing. But I found there were physicians and other medical professionals who love (or are at least willing) to write and were eager to contribute after all! I gathered and edited essays from practicing doctors and resident physicians, and to my surprise, I received an outpouring of contributions from medical students. I think that occurred because medical students are the newest to the profession, and possibly their earliest experiences are the most formidable and memorable to them personally.

Naturally, most of the stories are from my Indiana colleagues; and since I am a family physician, most are from family doctors, but some are from other specialists. In addition, I invited physician friends and colleagues from across the country who I thought might have a good story to tell. I also sought contributions from other health professionals including psychologists, nurses, physician assistants, and advanced practice registered nurses, but unfortunately received relatively few responses.

It is important to recognize that the narratives in *Family Practice Stories* are largely about how these physicians helped and enhanced the lives of the patients they served. And that's the direction that these kinds of narratives usually flow: Doctors positively influencing the health and wellbeing of patients.

So, it occurred to me that there is another perspective that needed to be told, one which has not been emphasized enough in the medical humanities literature: How patients influence and positively affect the physicians with whom they entrust their lives. This is a book purely about ways patients have enriched the lives of their physicians and other health-care professionals. It's not a one-way street.

Doctors certainly learn from their interactions with patients about how to better recognize disease and best treat patients medically. This aspect was minimized in the book. Rather, I was after what physicians learn about life and the human condition as well as learning about themselves, even their flaws and shortcomings exposed through their interactions with patients.

My father, Max Feldman, was a family physician in South Bend, Indiana, for nearly 40 years. I recall that he would frequently recount stories at the dinner table about patients he had seen that day. The anecdotes did not concern their medical issues but something interesting about the patients' personal lives that they had shared. My father knew his patients, not just their diseases. He knew and valued their personal stories.

Personal professional relationships develop between doctors and patients. This is especially true, but unquestionably not exclusive, for primary care physicians who treat patients over time and get to know their patients so well. These are physicians who earn the privilege to be invited into the lives of the people they serve.

Physicians are primarily trained in medical school and residency to diagnose and treat disease. Appropriately so. But they also need to be trained to interact with patients as people, effectively attending to the human dimension, the human exchange. Many excellent clinicians fall short in this

regard. This where the medical humanities, utilizing the narrative, can be so important in a physician's education and on-going development. It can be the path to more empathetic, sensitive, and engaged medical practice with enhancement of the doctor-patient relationship. It invites doctors and other medical providers to encounter insightful discoveries about the finest humanistic aspects of the profession and ultimately to learn from their patients. The door opens to not only becoming a better physician, but a better human being.

Physicians have a relationship with each patient, but they certainly are not touched, inspired, or humbled by every patient. From my own experience, most of the time it was from a special relationship that developed.

These relationships were very different with each patient and based on various aspects of our interactions. Some patients shared with me their life experiences or the wisdom they gained throughout their lives; sometimes we shared an interest in national and world events or political perspectives. Others were inspiring through their religious beliefs, their military service, or the love and devotion they displayed for spouse and family. It may have been founded on the way in which they conducted their lives, their dignity and character, their courage and determination through adversity, or sharing with me the historical events and times they lived through. Others simply shared with me a sense of humor or a love to banter during the office visit. Each patient in some way became someone special to me, someone I greatly respected, I felt close to, or someone I just always enjoyed seeing in the office. There was a bond. We enjoyed our interactions with one another on a very human, personal level.

There are unfortunately so many barriers that have developed in our contemporary health-care system to forming rewarding relationships with patients, and moreover, from experiencing gratifying careers. Physician burnout and the loss of joy in seeing patients is rampant due to the corporatization of medicine, employed status with loss of control, excessive paperwork, the electronic medical record, and enormous emphasis on productivity. Physicians today may have less opportunity to be truly present with patients, less occasion to know the patient and their life stories, and to learn from them. It's the price paid.

It is my belief that this book will resonate with the public as well as professionally with physicians and other health-care providers by celebrating the richness of what patients bring to the doctor-patient relationship. This is possible when physicians open their hearts and ponder the wisdom and life experiences of their patients. It requires mindfulness of presence where physicians absorb themselves in the patient and in the patient's story, blocking everything else in the world out even if only for a few moments.

Physicians are in a unique and privileged position. Patients come to us and share the most personal aspects of their lives. They share their loves, their joys, and their passions, but also disappointments, fears, tribulations, and even their secrets. Patients expose not only their physical wounds but their emotional wounds and scars as well. Pains that they may not share with another living soul. Every patient has a story. And if doctors will only take the time to listen, patients may become their teachers

of life's lessons. Establishing meaningful connections with patients adds purpose and meaning to physicians' careers and ultimately their lives. This is what this book intends to convey.

I am fascinated by the power of the narrative in medicine. And what better and enjoyable way to accomplish the goals of this book than by storytelling. After all, everyone loves a good story. I hope you will enjoy reading this book, and I trust that the stories contained within will inspire you and lead you to reflect on your own similar life experiences. For physicians and other health-care professionals, may this book remind you of the true rewards of your profession and why you entered it. For patients, I hope these stories will strengthen your confidence in the humanity of physicians and others in the health-care professions.

Learning from a Centenarian

I enjoy my elderly patients and routinely inquire about their memories of the past and their perspectives on contemporary life. I admire their values and wisdom, the history within them, their understanding of what is truly important in life, and their wonderful sense of time and place.

Their attitudes were often shaped by experiencing the events and challenges of the past that most of us can only imagine; a time that was without the conveniences and the medical and technological advances that we enjoy today.

Most rewarding is caring for my patients approaching the centenarian mark. I was privileged that my oldest patient gave me permission to write about her. Viola Kollmann passed away at 101 years old in Indianapolis.

This elegant woman walked briskly with her head up proudly, her shoulders back, and with a twinkle in her eye. She was bright, engaging, and informed concerning current events and issues. She read the editorial pages, and yes, she had her opinions.

She appeared at least 20 years younger than her age and was truly healthier than many of my patients in their seventies. Actually, it was hard to find anything to treat in this spry and spirited woman. Sometimes out of sheer routine and not considering her chronological age, I offered her preventative medical screening tests. She usually smiled and responded, "Now why would I need that test at my age?" I think she humored me in allowing me to treat her for most things.

How fascinating it was to hear her first-hand accounts of times gone by. She grew up in Fletcher Place in Indianapolis where she would watch the man lighting the gas street lights each evening. Viola saw William Jennings Bryan speak at the old Tomlinson Hall and heard John Philip Sousa at Garfield Park. She recalled the days when you could buy a loaf of bread for a nickel and ice cream for a penny. Viola recalled lying on her front lawn gazing at the millions of stars twinkling in the night sky free of pollution and the glare of electric lights. And she remembered the Armistice in 1918 when downtown Indianapolis exploded in celebration, singing, and throwing confetti because it was finally over, over there.

Mrs. Kollmann was the head of billing at Western Electric and was married to her husband, Frank, for 59 years. The Great Depression was a difficult time for her family. They had almost nothing but were

optimistic and learned "that good can come from misfortune, and that there is much to enjoy beyond what money can buy."

Viola lived during the time of few medical remedies and before the development of immunizations and antibiotics. Her sister Martha died at the age of 9 of typhoid fever, and other cousins and neighbors died of diphtheria, scarlet fever, tuberculosis and the 1918 influenza pandemic. Young healthy people routinely dying of acute infectious diseases were just a fact of life.

Viola volunteered as a guide at the President Benjamin Harrison Home since 1989 until she was 100 years old. She walked up three flights of stairs conducting tours and wondered why anyone would want to take the elevator and miss seeing the beautiful hand carved woodwork on the stairways. She also volunteered at the Wheeler Mission Ministries Ladies Auxiliary. She expressed, "It's never too late to start a good work."

Her family was blessed with good genetics. Three sisters lived into their nineties as did both her mother and father. Her brother only lived into his 70's but she is quick to add that he was a smoker. Viola believed that her longevity is more than good genes. She attributed her long life mostly to "practicing the power of the mind and strength of spirit and never losing my childhood sense of wonder and eagerness for learning."

Mrs. Kollmann was the healthiest and most remarkable centenarian I have ever known as a patient. She took lots of walks, ate a healthy diet, and watched her weight. But her formula for a long life was all about being young at heart and passionate about life. She teaches us important lessons.

Thank you, Viola for inviting this family doctor into your life.

The Craftsman

One of my most valuable lessons in professionalism was from a house painter many years ago. His name was Lube Rusomarov. He was the closest thing to an old-world craftsman that I have known. This middle-aged man from the former Yugoslavia spoke in broken English. He was highly recommended to me by a couple of friends who had used him. Like a couple other contractors that we had used during our historic house restoration, he came to see me professionally for specific acute medical issues.

If it was painting, plastering, or working with wood, he was very accomplished. He was a perfectionist and always insisted on quality work from himself and those who worked for him. Lube (pronounced Loo-bay) had an unusual passion for the old beautiful houses he frequently worked on, the materials he worked with, and the people for whom he worked. He took great pride in his trade and had a deep appreciation for true craftsmanship that is increasingly more difficult to find these days.

In the midst of restoring our historic old house, Lube showed me a door. As he hugged it, he said, "Dr. Richard, you can't buy a door like this anymore." He took me outside to admire the intricate raised timber-work fitted together with wood pegs. "Dr. Richard, you can't find craftsmanship like this today,"

There was an interior door that had a big imperfection. I decided to fix the defect myself and one day I proudly presented my "restoration" to Lube to evaluate. In horror, he said, "Dr. Richard, who did this?" After I admitted that I had done the work he responded, "Dr. Richard, from now on let me do it!". I did. I left it to the craftsman from that moment on.

Toward the end of the restoration, the house suffered a huge fire. The next day, I found Lube in the house crying. He was crying for me but also for the house that he loved so much and invested so much of himself in. For months, Lube would not accept any money for his work until he was assured that Dr. Richard was okay.

Lube and I would talk from time to time about things other than the house restoration. I recall he once spoke about his memories as a young grade-school boy in Yugoslavia. The Nazis were occupying the country, and he saw his Jewish classmates disappear one day, never to be seen again. The children understood what that meant and knew not to ask questions. I could see the sadness and anguish in his face as he related what happened many years before.

I also remember the time that I was caring for a Native American patient at the hospital. He was a Sioux from South Dakota who found himself in Indianapolis, alone, feeling isolated in an unfamiliar environment, and without a job. I inquired what past employment he may have engaged in, and he responded that he had experience as a house painter. The next day, I called Lube and asked him if he would take him on. Lube said that he had a full crew and didn't need any additional help. He paused and then told me that if this man showed up at 8 am the next morning at the jobsite, he would give him a job. Lube was, indeed, a sensitive and compassionate person.

When Lube died many years ago, he left me with more than paint, plaster and wood. He left me with a sense of professionalism that should exist in any occupation.

Concern has risen within the medical profession about maintaining our long tradition of professionalism in this era of escalating pressures and regulations and the corporate-like business ethic dominating the health-care industry. There is continual apprehension regarding medicine becoming increasingly depersonalized.

Patients easily become widgets, and pride within the profession erodes in the process.

We must preserve "craftsmanship" in the medical profession, and in doing so, the time-honored doctor–patient relationship. It should be a system invested in personalized, compassionate, and humanistic medical care that only true professionals can deliver.

When I was in medical school, I spent some time with my father who was a family physician in South Bend, Indiana. One day we saw a patient who couldn't afford to pay for my father's services. He already owed a sizable amount, but my father continued to see him and his family for their medical needs. His receptionist later told me that my father arranged for this patient to pay $5 a month on his account. Turning her head from side to side, she said that it cost the office more than $5 to collect this small payment every month.

That evening, I asked my father why he created an arrangement that made no business sense. He replied that it wasn't about the money. What was more important was maintaining the patient's sense of self-worth and dignity. My father, like Lube, loved and took great pride in his profession, and he cared about the people he served. A doctor and a house painter had much in common.

Where the Poppies Grow

Frank Shaw was a combat veteran of World War I. He was an elderly man who became my patient in the very early years of my practice. He was born into an Indiana farm family just before the turn of the twentieth century. Frank was probably a couple of years out of high school in 1917 and working on the family farm when the United states entered the War. He was tough, full of patriotism, and the spirit of adventure. He enlisted in the army because he wanted to do his part to serve his country and to help save the world from what he saw as Germany's evil aggression. Frank was engaged to his high school sweetheart, later becoming his wife of over 65 years. But that marriage would have to wait until he returned "from the war to end all wars".

Frank was obviously a hearty man in his youth; I could see it in this elderly man even still. He was a big man with that "all-American jaw". Frank was muscular and tall and still standing straight. He said in his youth, he was very strong and athletic and figured that he had "a better than even chance" in any fight with a German.

I probably never would have known that he was a World War I veteran, if I had not asked him. He wasn't the type to talk about it much unless he was asked; he didn't wear is military service on his sleeve. As we came to know one another better, he progressively opened up about his war experiences because of my continual questioning. I was fascinated. It was the historian in me who just wanted to know.

Although he told me of horrific events, he didn't seem terribly traumatized from the war in any lasting way, at least that he showed. He had a very calm demeanor. He was a pragmatic, humble person who just did his part for his country so long ago. He told me that while he was on the front lines in France a portion of his time there, he was no hero. He was proud to serve, but said more than once, "The heroes were those that didn't return home".

Frank was a typical "doughboy" of WWI. He described himself as just an enlisted man with a rife in his hand, a pack on his back, and carrying a few hand grenades. He entered the army and was given some training in the states and then additionally when he arrived in France. He voyaged to Europe on a large ship full of troops and worried all the way they might be hit by a torpedo from one of those German "U-boats". But the trip was uneventful other than the crowded conditions, poor food, and some seasickness. He was awfully glad to get off that ship and arrive at a camp in England, but the conditions

there were also far from adequate. Finally, landing in France, they were warmly welcomed by the French people. He was ready to fight.

Frank recalled the devastation of the French towns and countryside along the way to the front-line trenches. It wasn't long until he found himself in the thick of things. This certainly wasn't what he imagined when he enlisted. His naive thoughts and images of gallantry, duty, and triumph began to fade; his eagerness to fight without the real fear of being killed or wounded, soon gave way to the reality of the War's brutality, death, and destruction. It wasn't going to be as easy as was anticipated to defeat the Germans.

He soon experienced the filth, mud, insects, and rats in the trenches and the stench of the dead. The conditions were terrible and unimaginable. In some areas, the dead from both sides remained everywhere. There were times that there was hardly enough to eat and his socks and boots were wet for days. Disease was all around him. It was common for troops to die of disease rather than wounds suffered in battle, maybe more common, he said. Pneumonia, dysentery, tuberculosis, influenza, and other infections were always near. Frank recounted that he would look to the sky and see the American combat biplanes overhead. He envied those dashing airmen who flew above the mud and filth and returned in the evenings to their bases to hot meals, comfortable barracks, and clean beds.

I do not remember the battle fronts and the campaigns he engaged in, I only remember that he fought in France, probably mostly in the spring, summer, and fall of 1918. Americans fought in coordination with the French and English. He might have been at the Toul, Chateau-Thierry, or the Meuse-Argonne offensives. But I do recall his description of the fire and thunder of the allied bombs that proceeded their advances to the German front-line trenches to soften the enemy and their obstacles and barbwire defenses. I remember his descriptions of the anxious waits before being ordered to go "over the top" out of the trenches and running towards the German trenches in "no-man's land". It was here that the most terrifying aspects of the battles took place: Running through a hail of bullets whizzing around them and the earth-shattering shelling that fell on them with deafening and disorientating impact. Intermittently, they would jump into bomb craters for protection and then get up and run again. He saw friends blown apart by those bombs and others slowing dying of their bullet and shrapnel wounds. A few became debilitated and trembled with emotional "shell shock". They always worried about being gassed.

Finding his way to the German trenches, he did engage in some hand-to-hand combat with bayonets, knives, and firearms. "I killed some Germans", he said reluctantly as he looked down at the floor. But he recounted that he was fortunately only involved in intense hand-to-hand fighting a few times. Overtaking a German trench was many times more of a round-up of prisoners with sporadic fighting, as the enemy was overwhelmed with the effects of the preceding trench bombing and the resulting disorganization. He recalled, "We were certainly attacked by the Germans too, but we were never overrun. Overall, I was fortunate, it could have been much worse."

Frank reflected that somehow, he amazingly got out alive and without a major injury. He suffered a relatively minor shrapnel wound in the leg that earned him a Purple Heart. He showed me the scar. "I

was so lucky, unlike the many of my friends who fought along with me. I guess surviving was a crap shoot. I will always remember those young boys who were robbed of living their full lives." He recalled that there were times in battle that the justifications and reasons for fighting the War left him. He was merely fighting out of anger for those Americans who were brutally killed to avenge their deaths, I suppose. It was in those times that fear totally left him on the battlefield.

Frank Shaw was proud of his service and put it in terms of, "We did what we had to do". He believed in the cause to save the world from tyranny. But that experience, I believe, also gave him the ability to view the world with the eyes of a much more mature man who more fully appreciated freedom, family and community, and the value of life. And always, he realized that war is a tragedy, a waste of human life, and something horrific that no one should have to experience. He seemed torn between the necessity and the senselessness of war.

Frank did not normally display or disclose is service to his country to others. But every year around Armistice Day, he did something I thought was a little out of character. He would give his friends and acquaintances he happened to encounter a little red paper poppy with a small attached card. I received one of those poppies. The card contained that famous poem by Lt. Colonel John McCrae, M.D. of the Canadian Army, entitled "In Flanders Fields":

In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place; and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.

We are the Dead, Short days ago
We lived, felt dawn, saw the sunset glow,
Loved and were loved, and now we lie
In Flanders fields

Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.

Remarkably, I think the poem precisely reflects the tension that Frank felt in his soul: Believing in one's duty and the rightfulness of fighting the enemy in that great conflict yet lamenting the necessity and irrationality of war with its tragic enormous losses. I believe giving out the paper poppies was his tribute to his unforgotten fallen friends. I can only begin to imagine what his war-time experiences were like. But he gave me a glimpse.

Frank gave me a unique understanding of patriotism, sacrifice, courage, bravery, and commitment to something greater than oneself. All these things revealed in a person of great humility, selflessness, sensitivity, and humanism. A good combination, I think.

One day I asked him if he knew the song, Mademoiselle from Armentieres, so much associated with the English and American troops in WWI. How I was familiar with it escapes me. He responded assuredly, "Of course!" To my surprise, he proceeded to sing the first verse in a whispered voice, so no one would hear him outside the exam room:

Mademoiselle from Armentieres
Parlez-vous
Mademoiselle from Armentiers
Parlez-vous
Mademoiselle from Armentieres
She hasn't been kissed for 40 years
Hinky-dinky parlez-vous

At his next visit, he invited me to sing it with him. We sang together in whispered voices, and we smiled.

Frank eventually left Indianapolis to be closer to his two sons in his advanced age. We hugged at the conclusion of his final office visit, and he thanked me for the medical care he had received from me. I never heard from him again. I'm proud to have known him. He always wanted to return to France to visit the battlefields and the American cemeteries. I hope he had the chance to do so.

Frank gave me many gifts from the heart along with one of those paper poppies. I have it to this day.

He Can Hear Me, Really

This story is about the strangest experience that I ever encountered in my 40-year career. I was an intern on the intensive care rotation. I was assigned to an unfortunate gentleman, Mr. McGuire, who attempted suicide. He failed in his very serious attempt but was left with severe brain and kidney damage. He was unresponsive and thought to be comatose. He did not move his arms, legs, or head. He laid in his hospital bed unmoving with his eyes slightly open. He was certainly critically ill and would most likely die of his self-inflicted injuries.

I made rounds and examined him each morning and usually visited him a couple of additional times per day. During my visits, I greeted him by name and informed him of what I was doing. I told him that his wife has been at the hospital most of each day, and that I met with her every morning. I offered some small talk not expecting a response and never asked him a question. Afterall, I was told by the attending neurologist that his brain was gone, and that he was completely unaware of his surroundings. Indeed,

doctors and nurses would talk about his condition, prognosis, and treatment plans around his bed without any belief that he could hear what they were saying.

Several days after his admission, I thought what the heck, I would ask him a question to see if he could hear me and respond to me in some way. "Mr. McGuire, if you can hear me blink your eyes twice." He blinked his eyes twice. So shocked, I actually ran out of the room. I reentered the room and asked him, "If you can hear me, smile." He pulled his mouth back tightly in a smile. He could hear me! He wasn't comatose. He was severely brain damaged, but he could hear and comprehend. He probably had what is called "locked-in syndrome", aware but severely limited in responding in any way. One might say he was "locked in" his own body.

I found his nurse and told her what had occurred. She went to his room and asked him to blink his eyes. No response. Then I asked him to smile. No response. She looked at me like I was a nut case and left the room. I really didn't think I was suddenly losing my mind. Later that day, I returned to see him and asked him to blink his eyes twice. He blinked his eyes twice as before.

The next morning on rounds, I told the neurologist what had occurred the day before. We went to the patient's room, and he asked him to blink his eyes. No response. "Mr. McGuire, smile for me", he asked. Nothing. I tried as well. No response. The neurologist looked at me in the same manner as did the nurse the preceding day and reported, "His brain is squash, he can't hear you. Believe me!" Once again later that day, I returned to Mr. McGuire with my same requests and clearly received the same responses of blinks and smiles. No, I wasn't a nut case. I could not explain what was going on, but it was real. Was he playing with us? I asked him why he was responding to me only when I was alone with him, but of course he could not reply.

I met with his wife daily to update her concerning his clinical course and any progress he was making. I told her that although he would only respond to me for some reason, he was aware and could hear. I asked her to see if he would respond to her. At first, he didn't respond to her either, but eventually in the coming days he did and also to some of the nursing staff. He never did react to the neurologist's requests. Unfortunately, Mr. McGuire eventually died in the hospital of renal failure.

Why did he respond to me and not others? Did he trust me and not others for some reason? Did he sense something about me in my voice? Did he appreciate my little one-way discussions with him during my daily visits? Did he appreciate the simple respect for his dignity I displayed for him? I really don't think I will ever know for sure. But we did in some unusual way develop a relationship. Doctor-patient relationships may develop in unfamiliar ways.

But I know one thing for sure: Health-care providers (or anyone for that matter) should be very careful about what they say to "comatose" patients or to any patients thought unable to hear what is said in their presence. They may be hearing every detail.

Mr. McGuire certainly did.

Mr. Wolfe

I have always addressed my patients by their first names. Some in the medical profession consider using first names disrespectful to patients. But for me, it just feels comfortable and right. Afterall, as a family physician I get to know my patients extremely well over many years. Not unusually, a warm personal rapport grows between a doctor and a patient. And that's how it has been with me.

But there was one patient who I always addressed by his last name. That was Mr. Wolfe. There was something about him that made me a little uncomfortable. Was it the way he looked at me? Were there subtleties in what he said or the way he expressed himself to me? A cautiousness? A distrust? A dislike for physicians? I really could never put my finger on it.

He was an imposing figure, tall and slim with carved facial features. Although a bit formal and stiff, he was never unfriendly, always cordial, and not unpleasant. But I just knew somehow that it would be more appropriate and certainly more comfortable calling him by his last name.

I took care of him and his wife Anne for years. One day he came in the office with obvious changes in his right leg consistent with arterial vascular disease. His pulses were absent in his foot and the skin color was a violaceous-blue. He was having increasing difficulty walking without developing calf pain, and it was obvious that he had a blockage in the arteries to this leg. I recommended diagnostic imaging and proceeding with an urgent consultation with a vascular surgeon for an arterial bypass procedure.

In the hospital he did well post-op for a day or two, but then the lower leg became cyanotic and cold. The surgery failed, and all attempts to save the leg failed as well. For several days before his amputation I came in to see him on rounds and expressed how sorry I was about the poor result. Although I did not express it to him or to myself at the time, I think there was an element of personal responsibility for recommending the surgery. He finally looked at me sternly and said, "You know doc, it doesn't do me any good to have you come in here every day and feel sorry for me."

I just nodded and acknowledged his wishes. He was a strong person and accepted the unfortunate situation; it was time for me to do the same. In that moment, I understood that sometimes patients do not want sympathy from their physicians but only their best advice and support. That certainly was the case with Mr. Wolf. I think it was the first time (and fortunately one of the few times) that I experienced the emotions of having recommended something to a patient that ended in a bad result even though I knew it was the best course of treatment. Every doctor comes to know that some patients will unfortunately experience poor outcomes even if everything was done correctly. It comes with the practice of medicine.

I continued caring for Mr. Wolf for a long time and worked successfully through other health issues that he developed. One day in the office he looked at me squarely in the eye and said, "You really do care

about your patients, don't you." It wasn't really a question but a judgement he had carefully considered. And this time when he looked at me, there was a certain warmth to his face with the slightest of smiles.

I finally felt like I had gained his respect and responded, "Of course I do." Nothing more was said. I continued addressing him by his last name.

Fred Wolfe eventually came in my office with an unusual presentation of lung cancer with some odd facial lesions and chest pain, mostly when he stretched his arms straight out in front of him. He died a short time later. A few months later, I saw his wife, Anne, in my office. Toward the end of the visit she said, "I want you to know that Fred really liked you and he thought you were an excellent doctor." That was one of the greatest compliments I have ever received as a physician.

Anne asked me, "Did you know that Fred was an artist?"

"No, I had no idea," I responded.

"I brought something to show you." From a bag she pulled out one of the most beautiful, delicate, and sensitive landscape paintings I had ever seen!

"Fred painted this?" I asked.

"Yes, he was a wonderfully talented painter, wasn't he? He painted for many years. He just loved to paint. I just wanted you to see this." She went on to say that he was generous person and much loved by his family and friends. She missed him very much.

I had to earn Mr. Wolf's respect and trust. He was obviously a good man and a warm, sensitive individual. Patients are not always what they seem.

Courage

As with virtually all practicing physicians, I've had patients die throughout my career. These are difficult experiences, especially with those patients I became very close to and cared for over many years. I remember the loving older couple who brought me a big jar of cookies they baked very Christmas. She died of a melanoma and he died of renal failure just a couple of years later. I remember the grandmother, the matriarch of the family, who died of COPD and congestive heart failure. There was the old man who died of liver cancer and patients who died of lung cancer. I recall the woman with pancreatic cancer who

chose to die without treatment and without artificial means of nutrition or hydration in a nursing home. There were of course many others.

I am struck by the fact that nearly all my patients with terminal illnesses faced their end with dignity and courage. They accepted their fate bravely and expressed that they were fortunate to have lived such a good life. They were thankful for what they had. They had no regrets. Some were more concerned for the loved ones that they were leaving behind than for themselves. Such was the man who died slowly of a progressive degenerative neurologic disease. Near the end, he met with me privately to discuss the future well-being of his wife, Karen, after he was gone and to thank me for the care I had given them over the years. They had no children, and I promised him that I would make sure his wife Karen was doing okay. Courage and love.

There was another individual and friend, Jim Shrack, who lived in my hometown. Over the years he would call me for medical advice and opinions. I was in a way his "part-time" physician.

Jim was in my wedding and was one of my best friends since college. We even lived together for a time when I was in medical school, and he was working in Indianapolis. Many years later, he developed an unusual and incurable gastrointestinal cancer. Once again, he called me for my opinions and advice. I provided him with what information I had to offer and explained aspects of his disease and potential treatments he did not fully understand. I consulted with some of my oncology and surgical colleagues to give him the best advice possible. Along the journey of this final illness, I reviewed his treatments and medications and helped him make decisions regarding the best medical center choices to consider for his treatment.

He underwent chemotherapy and two surgeries. Initially his oncologist was hopeful that with treatment, he could live a few years. After his round of chemotherapy and abdominal surgery, his doctors were more hopeful for even longer-term survival given the specific type of cancer found on his pathology report. Unfortunately, the cancer progressed with a vengeance leaving him with extensive intestinal obstructions. Further chemo would be of little help, and further surgery was impossible.

My friend Jim was left with only the ability to drink water and some sugary drinks. He could receive no real nutrition. He was advised that he would essentially starve to death. And indeed, he did. He died a week after I last saw him. He had lost 65 pounds in 10 weeks and was essentially skin over bone. He really wasn't in excessive pain, although he took some opioids and nausea medications during his terminal illness.

Jim was Catholic, very religious, and belonged to a charismatic community. He was a good husband and father to his nine children. He worked hard, was responsible, and was a good citizen. He was a good man. The best.

When I last saw him, I told him that I envied both his courage and his faith. He had no doubt that in passing, he was entering the next phase of his life, and that he would be with God. He had no interest in anything that would extend his life and was not afraid to die. He thanked me for being such a good friend over so many years.

He told me that after he was gone, if I ever was in a difficult situation and needed God's help, to let him know and he would do his best to help me. This was not a reflection of a sense of superiority or specialness; he was a humble individual. He just believed he had a personal relationship with God and Jesus, just as everyone believed in his religious community. This was an unusual conversation for us to have because although a very religious Christian, he never wore it on his sleeve, at least with me, his Jewish friend.

My friend's courage, character, and faith carried him through. I think of my courageous friend often.

When a Patient Reminds You of Someone You Know

Richard D. Feldman, M.D.

Have you ever met someone who really reminds you of someone else you know well? It could be the sound of his or her voice, mannerisms, or facial and other physical characteristics. There is a natural human tendency to redirect your feelings for this individual, either positive or negative, to the new person just encountered. It's called "transference". It's probably close to the conditioned response we learn about in psychology 101.

One almost anticipates that the new person will share similar interests, talents, shortcomings, beliefs, actions, or personality traits with the previously-known person. My wife and I recently met a young man that looked like the twin of one of my nephews. Everything about him appeared exactly like him, even down to his voice. There was the initial natural expectation that he would be exactly like my nephew in every way.

In the medical relationship, transference refers to a patient's feelings towards the doctor or other health professional through the process explained above. It can certainly affect the doctor-patient relationship either positively or negatively regardless of the actual actions, attitudes, and personality of the physician.

Another phenomenon is referred to as "countertransference". In this case, the situation is the opposite: the redirection to the patient of the doctor's feelings for a person already known because the patient reminds the physician of that person. Again, it could be positive or negative. It might be a person from the physician's personal life or even another patient. We have all experienced the phenomenon of transference in our lives.

I particularly remember two patients that involved countertransference. Both experiences were fortunately very positive.

Otto was an elderly patient originally from Germany who immigrated to America sometime between the two World Wars. His English was excellent but still had a moderate German accent. There was something about his facial features and his accent that absolutely reminded me of my grandfather who immigrated to America in 1907. Otto was a comparable size to my

Grandpa Harry and had a similar walk. There was a certain toughness about him, typical of that generation that came to America and built a life here.

I instantly felt a warmth towards this old man, and it lasted until the day he passed away. I always loved to talk to him about the “Old Country” and asked him questions about his life experiences. He was much like my grandfather in many ways. It was like talking to my Grandpa Harry again, and I enjoyed it.

I always enjoyed seeing him in my office and during his hospital stays. I took a special interest in him, and I think a major reason I did so was because it was like having my grandfather back again. He was one of my special patients, and when he died I emotionally felt like my grandfather had died again.

I entered medical school to become a psychiatrist, and before switching to family medicine residency training, I spent a year in the Indiana University School of Medicine Psychiatry Residency. One of my first hospitalized psychiatric patients was Erica, a young woman with wavy auburn hair. She was schizophrenic and was hearing not-so-nice voices. They told her to do things that she felt was wrong and that she was a terrible person. She was far from terrible and was a sweet, engaging, intelligent, and talented person. She was also an excellent artist and while hospitalized focused on creating abstract sculptures. I’m not big on abstract art, but I liked her work.

When I looked at her, she greatly reminded me of a very close college friend, Debbie. Debbie is best described like a sister to me and we keep in contact to this day. Erica did not particularly share any personal attributes with Debbie other than a pleasant demeaner and an artistic flare, although in different ways. Erica was an artist, Debbie a musician with a July Collins-like voice. But there was something striking about her appearance and her presence, which just wonderfully smacked of Debbie.

Again, I became very close to this patient. She was special, and I spent extra time with her daily in the hospital talking her through some difficult times. Unfortunately, despite various attempts with multiple medications, she wasn’t making much progress with her thought disorder. I was clearly aware what was going on with my countertransference, and it undoubtedly was a big factor in my approach with her. I had such a warm feeling for Erica. I wanted her to get better and for her emotional pain to end.

When I left the rotation, she gave me a hug and presented me with one of her sculptures. She thanked me for all my time and help. I told her she would do well and to hang in there. I never saw her again and have no idea what happened to her. But somehow, I believe she is doing well with the advances we have made in psychiatric medications since I cared for her over 40 years ago. And besides, like Debbie, she possessed strength of character and had depth of personality on her side.

The relationship between doctors and patients are sometimes not entirely straightforward and can be influenced by emotional entanglements involving persons not involved in the therapeutic relationship. I’m fortunate mine were positive ones.

Epilogue

Relationships

Most every story contained on the pages of this book is about how physicians have been touched in some way by their patients. In the final analysis, I really believe it's much about the development of close meaningful relationships between doctor and patient. How can it be otherwise?

One will note that many of the stories in this book involve life and death situations or the death of a patient. This is what I naturally anticipated as nothing is more poignant for a physician or other health-care professional than the loss of a patient. Experiencing a death may be an entryway to a better understanding of life.

Over the years, I have gone to the callings or the funerals of patients with whom I developed especially close relationships. This is certainly not unique to me as a physician. Nothing underscores the significance and the personal aspects of these relationships more than a physician's desire to attend these final events.

For me, these patients were all very different people with diverse personalities, backgrounds, beliefs, values, and life experiences. A unique relationship developed with each, and for reasons that I find difficult to articulate, I felt compelled to attend their final tributes to say goodbye and to let the family know he or she was a remarkable person who I admired.

I remember the funeral I attended for an elderly patient of many years. As I greeted the family, also my patients, to my surprise my voice cracked as I expressed my condolences and that he was a good man. I had lost something along with his family, and I shared some measure of grief with them. When other special patients died, I felt like I had lost a grandparent or close friend. It was that distressing.

I recall the time that one of my long-term patients was admitted to the hospital. I was out of town, and the residents on the inpatient service under the guidance of faculty cared for her. Her condition was failing quickly. The two residents, despite the short time they treated her in the hospital, became very close to her. When she died, they decided to attend the funeral, certainly because of the feelings they developed for her, but also to represent me. They understood she was one of my special patients. How kind and big-hearted.

Sometime later, I saw my patient's husband in the office. He told me how much he appreciated the resident physicians attending the funeral. He looked at me reflectively and said, "I don't know who cried more, me or your residents?"

Hearts touched by sweet relationships.

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