# A Patient's Angry Spouse Helped Me to Become a Better Physician

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While working as a hospitalist in a small town I was paged to the emergency room (ER), to admit a 62-year-old male who had a lingering cough for 2 months. He appeared medically stable; initial blood tests and chest x-ray did not show any pathology. The ER physician apologetically told me that he did not think the patient required hospitalization, but had called me as the patient's wife insisted on admission.

On rounds the next morning, the patient mentioned he had worsening of upper back pain. I learned that 2 months ago he had an episode of fever and chills with sputum production that had resolved spontaneously and he did not seek any medical attention. I ordered a computed tomography (CT)-chest for further evaluation and told the patient that if CT came back negative, I would be able to discharge him.

An hour later, the nurse called me stating that his wife had arrived and wanted to talk to me. She was furious that I was planning to discharge her husband. I explained to her that I was awaiting his CT results, on which I would base his disposition. She calmed down, but immediately she asked for a magnetic resonance imaging (MRI) of his spine. Her relative had back pain for 3 months and was recently diagnosed with multiple myeloma based on MRI results. I explained to her that I did not have objective data to suspect multiple myeloma in her husband, and no indication for a MRI. Her body language clearly indicated that she was dissatisfied with my response.

Later that day, the CT revealed bilateral empyema and thoracic vertebral osteomyelitis. I was surprised, but felt gratified as the CT had led to the diagnosis. Subsequently, the patient underwent a CT-guided biopsy of the vertebrae, after which he developed lower extremity weakness. MRI spine showed an abscess in the epidural space, necessitating emergent surgery and transfer to intensive care unit (ICU).

When I went to see the patient in ICU, his wife began yelling at me, accusing me of being the "sole reason for her husband's suffering," claiming that had I ordered an MRI when she requested, we could have prevented all the complications. Feeling embarrassed and downcast, I left.

As I walked out of the room, I questioned my judgment. Had I missed some vital history by not being attentive to the wife's concerns? Why was she so adamant about admitting him, and later resisting discharge? What was behind her frustration? Perhaps if I had waited for CT results before discussing the discharge plans, I would have avoided the unpleasant interaction. Perhaps, when I noticed she was dissatisfied with my response to her MRI request, I should have acknowledged it. That might have opened up new avenues for conversation. I rationalized that I was trying to save time by discussing discharge before all the testing had been completed and be efficient by ordering only tests that were clearly indicated. As hospitalists we are trained to be attentive to metrics such as length of stay and cost-efficient care. However, I questioned if I had been unduly influenced by the ER physicians' heuristics or compelled by hospital performance standards.

One of the consultants heard what had transpired. To my surprise, he called me. He validated that I had done everything that I should have, and advised me not to take it personally when things go wrong. I had been riddled with self-doubt, lack of confidence, and guilt. The empathy and understanding offered by this colleague gave me solace and rekindled my confidence. Later, I ran into another physician who recounted the wife's bitterness against me. It was clear that, without checking the facts, he had judged me. His sarcastic smile stays imprinted in my memory as a mark of lost respect. I was wounded and the unfair criticism damaged our personal relationship.

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In the final analysis, my greatest regret was that I did not explore the wife's extreme concern, perhaps falling into the trap many physicians do: avoidance of the difficult family or confrontation. The empathy conveyed by my sympathetic colleague certainly had a therapeutic effect; yet I wondered what may have prevented him from advising me, to reconsider the situation and what I could have done differently, or how I could learn and grow from the experience. Despite all the obstacles, taking the time to fully explore a patient's or family's concerns can lead to correct diagnosis and a satisfied patient, and is just good medicine.

A year later I joined a residency program as teaching faculty. When I come across a demanding patient or family, or a despondent resident whose patient did not do well despite best efforts, I share my story, and how I learned to be more conscientious and empathic. I emphasize the obligation and necessity of putting the patient first, by good listening and acknowledging families' concerns. Although quality metrics are helpful to our growth as physicians, our primary obligation is to the patient. I also try to help residents acknowledge and admit that despite our most objective methods of treatment the outcomes are not always predictable or within our control. When patients or families cast blame, the most productive approach is to be humble and receptive, analytical and reflective.

From this experience, I learned the value of searching for the lessons in each mistake, and extending empathic support to peers and students. We support one another best by avoiding unfair criticism and unconditional approval. Above all, we need to be able to process difficult clinical situations in a safe environment and be given assistance as we try to learn and grow.

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