

## Leaving the room: A method of patient-centered care?

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Welcome to the CanMEDS communicator multiple-choice exam: Q: A 67-year-old is in your clinic in followup of a routine laser lithotripsy; she is pain-, stone-, and stent-free. As you wish her well and plan discharge, she turns the discussion to the hip pain and leg edema that have been bothering her. Her family physician closed their practice eight months ago. Which of the following best adheres to the principle of patient-centered care (Comm 1.1,1.6)?

- Listen to her with empathy and clinical acumen; use your medical expertise to identify red flags pertaining to her described symptoms.
- Hear her out, then state, "I'm afraid I'm out of my depth, but I can tell you it won't affect your kidney stones."
- Seek a moment to interrupt early, then state, "I'm sorry, I can't help with this and have to keep my clinic going. I hope things improve," and close the encounter. You have 23 other patients on your afternoon slate in need of your time
- Fix your gaze on hers, then slowly lower your eyelids. Press your index finger to your lips. Shake your head almost imperceptibly and let out an endless hissing, "Shhhhhh," like a Giant Tiger air mattress ruining your camping weekend

I'm a recalcitrant (b) most of the time. I can't tell if it's empathy or an attempt to avoid being the subject of patients' ire or confirmation bias that the system is against them — my internal monologue registers both. What's for certain is that I'm never happy it's happening, and my mind is outside the room on those 23 other people. But really though, which is correct? What if the patient instead turned the quick postop visit into a LUTS discussion? Must you reboot for an essentially new and unplanned consult?

I'm a wee bit nervous discussing "patients" in anything but wholly reverential terms, so I'll get this out of the way. You should probably

stop now if you think the customer is always right. This is not a "hell is other people" polemic, just a note of empathy for my fellow clinicians around the fact that *knowing urology* is such a surprisingly small part of *practicing urology*. Let's also get *this* out of the way: a) there are plenty of jerks out there; and b) some of them become your patients. Interacting with jerks is exhausting, deflating, and imparts a residue that colors subsequent interactions. This is really very rare in practice. Unhappy ≠ jerk. If not, recall the adage, "If you met a jerk this morning, you met a jerk. If you meet jerks all day, the jerk is probably you."

The idea that one ought to practice in a patient-centered fashion is table stakes in medicine — paternalism evokes a gag reflex in the #MedEd world. What's not clear, and is hard to articulate, is the slope between patient-centered and patient-driven, whether endless tweaking of care for marginal gain, indulging low-relevance clinic-busting expositions, sparring over minutiae in the HPI or the labs, or just following asymptomatic people in the specialist clinic for years "just in case" of a change. Note this is not simply "unreasonable patients"; it's often our own instinct to provide the best care that drives us to acquiesce.

Let's take a tour of some phenotypes that we see every day. Be aware that you are probably one of them when the tables are turned! You are ready for clinic — a routine afternoon and the waiting room is bubbling to life. The first patient is an engineer by trade, and within 45 seconds you are scrambling to defend, saying, "Your PSA is 4.0, last year it was 3.9, so basically the same," when the numbers are clearly different. Next is a fourth-time stone former with 1100 cc of urine output per day. Easy peasy! Except he says he doesn't like drinking water. A patient has answered, "How often do you get urinary infections?" with the unhelpful "A lot." The next man's daughter is with him, and she has a clipboard with a WebMD printout. The next's son opens with a screed on how stupid the doctor at the walk-in was. One

handles your stated options with, “You’re the doctor” and yours is the third opinion of another’s doctor shopping. The next doesn’t want to be on a pill forever. This 87-year-old is not having your case against PSA screening; the 57-year-old with the PSA of 8 has come to understand that the test is no good.

Very early in that paragraph, you determined that I’m the jerk, right? A wee bit of hyperbole as always, maybe, but I’m here to say that all of these are reasonable and normal patient perspectives! We don’t live their lives and are fortunate not to be them on that day, in a low-information state at the specialist’s office. When I’m at the accountant, I see her exasperation when I don’t know the first thing about my finances and say things like, “You betcha,” and “Probably” to very specific questions. At the car dealership, I’ll say, “There was a sound like ‘bububububuh’.” Even at the family doc’s, I’ll cluck that my 138/89 is white-coat and “What if I take fish oil instead of Crestor?” It’s all domain-dependent.

At the level of the single encounter, surely there’s little harm in hunkering down and indulging off-topic monologues or off-target takes. There is information here, about patient perspective and values, as well as a helpful re-ranking of their health priorities. This may also be therapeutic — face time with a doctor can be hard to get, so offloading these issues may scratch an itch for the patient. But it’s still a huge drag to feel time slipping away while there’s no forward progress. I think it’s important to be frank about what powers you have to help here though, and if empathy is all you have to offer, make that explicit!

A clinic is more than a series of single encounters. To provide care within a practice means rationing time. Giving eight people 30 minutes each is to deny access *at all* to the majority. It is thus defensibly patient-centered to recalibrate or call time when the encounter

veers off course, or to assert oneself as the expert in the room, so that the other people waiting are given a fair shake at their own visits. The answer is probably (c).

Patient-centered care is also not fully congruent with patient satisfaction. The latter is mostly laudable, but at the margins, “satisfaction” bakes in the idea that one leaves an encounter having *gotten what one wants*, which in medicine is not synonymous with the best care or health outcomes. Obvious examples are spurious antibiotic or pain prescriptions, but this can extend to cessation of low-evidence surveillance, insistence that lifestyle modification has the best chance at helping, or condemning to life with a catheter when surgery is futile. Futility can be a fantastically difficult thing to articulate and to accept (it even invites the word “condemn” to sneak in as its companion) but is often merciful and the most appropriate care.

Again, I approach any insinuation that patients are impugnable with great hesitation, but there it is. The primary care apocalypse means that patients will unfurl their suite of worries, or their skepticism or exasperation, on the next MD they meet, which is often you. I write this with deference to the fact that we *all* have motivations, domain-literacy, and anxieties that fluctuate between facets of our lives. The point here is that communication skills — not just empathy (Comm 1.1, 1.2, 1.3) but the ability to adapt to different health literacies, information needs, and personalities — are the essential tools that complete the work of patient care. The grasp of urology as a medical science takes years to achieve. It is then that the vagaries, joys, and frustrations of translating that knowledge into care in the world happens, and it is hard. Do your best, try to keep getting better, and empathize with each other, your accountants, mechanics, and servers.

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