Cranial Nerve VIII

I HAVE KNOWN many physicians who seem to harbor a genuine nostalgia for their training years. They recall them fondly as challenging but invigorating times, a purifying forge in which new healers were formed and tempered. My own reminiscences are somewhat less heroic. I can recall more than a little sleep deprivation and frustration. But it is a necessary experience, and it must be conceded that we learn things in training that stay with us for the rest of our careers.

I learned something 15 years ago on a brilliant spring day full of promise, which would never be realized by my patient of the moment. He was dying of cancer, and I had been dispatched to draw his blood for a lab test. The results would be of no particular benefit to the patient, but were apparently of mild interest to one of the several physicians charting his downward trajectory. It was an easy draw. His arms had once been powerfully muscled, and they still had prominent veins that even a medical student could not miss. I carefully set the specimen aside and reached out to release the tourniquet. In my peripheral vision, I saw the vacutainer tube roll treacherously to the edge of the table and dance away from my lunging fingers to crash colorfully to the floor. My frustration found voice, and I muttered a single word, "Damn." Somehow, through the fog of morphine and the ambient noise of a busy hospital ward, the patient heard me. As I watched the expression on his face change, I realized that our patients really do listen to us, and often with a fearful intensity.

In a formal sense, we are taught very little about how our patients listen to us. This is surprising, given the importance of the subject. In fact, the only specific thing I can remember being told was a general admonition against speaking too freely in the presence of a comatose patient. It struck me as a sensible rule, because they do occasionally wake up and remember such things. We were told this in tones that were so solemn that I wondered if it could be the vestiges of a taboo from the very beginnings of the healing profession, from a prescientific age when the shaman had to worry about displeasing the spirits of those who walked outside of their bodies.

There are many other ways that our patients hear us that are far more applicable to our daily practice. Some patients choose not to hear certain things at all. This will come as no surprise to every clinician who has tried in vain to talk a patient out of various self-destructive behaviors. They remind me of one of the newer phone answering systems that can be programmed to ignore calls from unwanted salespeople and out-of-favor relatives.

On occasion, one does find patients who listen in an entirely literal sense. They pose a unique set of challenges. Some years ago, an acquaintance of mine was working in the emergency room on a chilly winter night. While treating a patient with a sprained ankle, he suggested that the application of ice might be helpful. In some fashion he implied that the nearby snow drifts would work. I assume he was trying to be mildly humorous, but the result was frost-bitten toes. Fortunately, such uncritical listeners are rare in these skeptical times.

A far greater problem are the many patients who have hidden agendas based on fears, suspicions, or past experiences. Some patients may be cancer-phobic and take the briefest hesitation we make in conveying normal test results as confirmation of their nightmares.

We do not always know what lies beneath the surface of a person. Very few physicians are blessed with the wonderful gift of instant rapport. Most of us get along as best we can, stepping carefully in the vicinity of sensitive issues such as sexuality and substance abuse. At its most difficult, the physician-patient relationship can be like a cautious sortie across a now quiet battlefield, where all manner of deadly, unexploded ordnance lurks unseen.

Try as we may, it is hard to know our patients well enough to avoid these pitfalls, even in the more personal specialties. I suspect that it has always been hard, and now, in a day when blocks of patients are bought and sold like HMO chattel, it is even harder.

Sometimes I think back with regret to the man dying so incongruously on a spring day full of life. I would like to say that he was one of those inspiring patients who stand strong and unbowed in great adversity, finally succumbing peacefully and with their affairs in good order. But it was not so. His death was an unpleasant ordeal, as the cancer within him scorched away progressive layers of dignity and competence. At the end he raged in delirium.

I have a good, if cluttered memory, but there is much about the listening sufferer that I cannot recall. Of course, like anyone trained in the ways of Western medicine, I remember his final pathology report: gastric adenocarcinoma. I remember our attending physician, a rheumatologist out of his element, trying to console the grieving widow. She asked the same hard questions that we asked ourselves: Had we done enough for him? Or too much?. But I do not remember his name, or what he did for a living, or his hometown, or whether he had children. I do not even clearly recall his face, as it has blended into a sort of generic deathmask that I have seen too many times over the years. But I will always remember his eyes: When he overheard my muttered oath the look in them was one of fear.

It is hard to know our patients well enough. So I have no idea if he was a believer or an atheist. If he was a good man or a bad one. I will never know if he had good cause to fear the specter of damnation I unwittingly invoked.

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