# Does This Sound Familiar?

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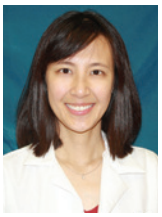

A 56-year-old woman appears in your ED with abdominal pain and slight dysuria, saying it feels as if her bladder is pushing on her intestines. She is completing a one-week course of nitrofurantoin for a UTI diagnosed by a local urgent care physician. She has a history of chronic abdominal pain and multiple surgeries related to partial bowel resection for gangrenous bowel. She's on methadone, oxycontin, and oxycodone while she's allergic to ibuprofen, ciprofloxacin, tramadol, and naprosyn. She says the pain has been present intermittently over the past three years, and the current flare has worsened over the past week. She denies vomiting and otherwise has a negative ROS. Vital signs and labs are within normal limits; urinalysis is still pending. On exam, there is mild tenderness to the right lower quadrant and suprapubic region without peritoneal signs.

Before I ever entered the room, my bias led to judgments about this patient. Even my eager scribe rolled his eyes. With chronic abdominal pain, multiple narcotics, and normal labs I anticipated she would tell me that, "Only IV Dilaudid, Benadryl, and Phenergan work for me." Or maybe she would inform me that she needed admission because she just didn't feel good. Or perhaps she would claim that no one had ever properly diagnosed her and that she wasn't going to leave until she had answers. After my exam I said something to the effect of:

> "Mrs. X, the good news is that your labs are normal. I don't think your bladder is actually pushing on your intestines enough to cause this pain. You are already on high doses of narcotic pain medications and I can't give you more. Ultimately it is important that you see your surgeon and urologist to find out if there is anything they can do, but because you've already had so many CT scans, I don't think it's a good idea to have another and be exposed to more radiation. Is there anything else I can do to help you today?"

I braced myself for a fight about opioid dependence and refusing to prescribe additional narcotics for her chronic abdominal pain. I could always blame the nebulous "they" as the reason I wasn't allowed to give her narcotics and reiterate that she needed to follow up with her surgeon or primary doctor or urologist or anyone besides me. I secretly hoped she would accept my blame-shifting as reason to deny her medications.

Then, she surprised me.

She acknowledged my response, and asked if she could get some IV fluids and acetaminophen. Then, as I left the room, she said, "Oh doc, one more thing…" I rolled my eyes. Here it comes ... but, all she asked was, "Can I have more antibiotics for my urine infection?"

Fast forward about one hour — CT negative and UA reveals likely resolving vs. resistant UTI. Now how do I discharge her? To my surprise, she agreed with our plan for follow up and felt better after IV fluids and acetaminophen.

No way was it going to be that easy.

"Oh doc, by the way…" Here it comes, I thought, a request for refills on her narcotic, a short prescription for something until she could see her doctor, just one shot of Dilaudid before she left… but, instead, she said, "Doc, I've been coming to this hospital for years. My father died here, my husband, and son died here, I've been here myself several times. I've never been treated so kindly and had such a complete exam. Thank you."

> "We have the opportunity and obligation to lead by example. It starts with remembering why we chose the privilege of practicing medicine."

This gave me a moment's pause, but then she said, "There's just one more thing…" Ah-ha! She was just trying to butter me up. "Can I have a dose of Tylenol to go before I am discharged so that I don't have to stop at the store before I go home?"

I was then truly humbled. And embarrassed. I had been a biased jerk in my thoughts, even if my actions did not parlay my inner frustration and contempt.

It was a not-so-subtle reminder about the importance of humanism in medicine. The nonverbal cues we exude do not go unnoticed by the rest of the team or medical students. We have the opportunity and obligation to lead by example. It starts with remembering why we chose the privilege of practicing medicine.

I was once asked by a young teen whether I liked my job, and I responded with a hearty "Yes!" When did I allow my biases to penetrate my idealism? I have no right to judge. I do not know the hardships and horrors this or any patient has likely been through. While I am certainly not naïve enough to think I will always be free of bias, this experience was a helpful reminder about humanism and why I wanted to be a doctor in the first place. ■