

Listening in the “Hear and Now”

Ambar Mehta, BS

Edward J. Wright, MD

I knocked on the door, entered the room, and introduced myself to Peter and his parents. Peter’s severely arched neck prevented us from making eye contact. A 28-year-old man, Peter’s problems included kyphosis, chronic fatigue syndrome, postural orthostatic tachycardia syndrome, chronic headaches, iron deficiency, and transient neuropathic pain, among other issues. He now presented to the urology clinic for the first time, where I was working as a rising third-year medical student.

Dr Wilbourne, the urologist, had given me clear instructions: “Take Peter’s history and tell me what you think.”

Three months ago at another medical center, Peter was evaluated for possible tethered cord syndrome—a type of spinal cord malformation. One examination evaluating his bladder revealed an elevated postvoiding residual volume of 140 mL. The workup reached a devastating conclusion. Peter was not a candidate for surgery, and he would likely require intermittent self-catheterization for the rest of his life.

Appreciating the neurology governing voiding function, I asked him several questions. “Do you have any urgency, incontinence, or strain to urinate? Balance problems, leg weakness, or numbness? Any bowel problems or urinary tract infections?”

Peter denied having any of these symptoms, and he stated that his kidney function was normal and that a urethral catheter had passed without difficulty during a prior evaluation. I was confused. Was he answering my questions honestly?

One thing was certain: Peter conveyed no emotion throughout this conversation. He appeared resigned to yet another addition to his problem list. Only a few times did his tone betray his feelings, when he spoke of piling another burden onto his family.

Eventually, Peter’s mother offered that her son had undergone an operation for a urethral stricture 8 years earlier. “I don’t know if his current problem is a product of that stricture, if it wasn’t fixed properly, or if this is a recurrence we could have prevented . . . ?” She seemed to seek reassurance that the problem was inevitable rather than preventable, and her anxiety for Peter and his future was evident.

I did not know how to respond.

Minutes later, I carefully combined Peter’s medical history and current presentation into an assessment and a treatment plan. The elevated postvoiding residual signaled his bladder was failing. In the context of potential spinal cord tethering and his other problems, I prepared for the worst.

Creating the differential diagnosis was challenging, but not the most arduous task. Peter’s parents appeared anxious, scared, and were carrying a crushing sense of guilt. This seemed to stem from wondering that if they had been more proactive in their son’s care, Peter would not need lifelong catheterization. But how to capture this emotion in my assessment?

Before Dr Wilbourne sat down, I began describing Peter’s story, finishing with my plan. I restated Peter’s elevated postvoiding residual and declared that a recurrent urethral stricture or a neurogenic bladder from the tethered cord seemed the most likely. “I would suggest cystoscopy, urodynamic testing, additional bloodwork, and imaging of . . .”

“He’s fine,” Dr Wilbourne interjected. He saw my puzzlement. “Ambar, are you treating Peter or that test?” I just stared as the rhetorical question dissolved in my mind.

“You asked all the right questions and listened well,” Dr Wilbourne explained. “They’ve shared everything you need to know. There’s no need for further invasive testing, and self-catheterization won’t be necessary. Let’s go tell them the good news.”

“But Dr Wilbourne, how do you know this?”

“Peter told you he has experienced no dysuria, frequency, or any urinary symptoms. His renal function is normal and urethra is open. How does this stand up against a single postvoiding examination?” Dr Wilbourne responded.

In my zeal to make a diagnosis, I had gotten lost in what has been described to me as the “medical-industrial complex.”¹ The advent of numerous medical technologies has allowed physicians to hone their diagnostic abilities. Computerized tomography scans, magnetic resonance, and molecular imaging comprise just a few of these. However, every increase in diagnostic sensitivity from better technologies precipitates a greater number of false positives. Incorrect diagnoses and incidental findings, in up to

39% of patients,² can push patients down a treacherous path.

I neglected to corroborate the results of Peter's postvoid residual with his actual story. Instead, I subconsciously separated Peter's examination data from what he told me. All the while, Peter's care demanded a synergy between the two.

How did I fall into this trap so easily? Did Peter's complex medical history prompt a belief that there must be an underlying pathology? Was it the history of urethral stricture, or the prior physician's diagnosis that Peter would need to self-catheterize? The easiest scapegoat would be my lack of 20 years of experience that Dr Wilbourne carries with him. And then it hit me—a quote from Sir William Osler that was shared with my class during third-year orientation: “Listen to the patient, as they are telling you the diagnosis.”³ I neglected to follow this key lesson.

This became more evident when we entered the room and Dr Wilbourne simply asked, “Peter, what do *you* think is going on?” Peter, seemingly taken aback by the question, responded, “I don't know; I think everything is actually fine.”

For the next 30 minutes, I watched Dr. Wilbourne patiently explain to Peter and his parents that there was nothing worrisome with Peter's urologic function. In fact, regarding this bodily system, Peter was entirely healthy. His postvoiding residual had just been a red herring. They were relieved that no further tests were needed, and most of the visit was directed at addressing their initial worry and vindicating their collective vigilance over Peter's health and well-being.

The medical literature constantly reminds us of the positive impact of advancing medical technologies. Few studies have examined the potential negative ramifications. When they do, they discuss receiver-operator curves, utilization costs, overreliance, and access disparities. What is even more rarely described, and harder to articulate, is the emotional toll on patients. Learning about a major but ultimately incorrect diagnosis placed additional burdens on this family. Peter may have felt guilty for disappointing his parents with another illness, while his parents carried the emotional weight of believing they shared responsibility for their child's damaged urinary function and the new need for self-catheterization.

They were dedicated, attentive caregivers shackled by the question: Did we not take care of our son?

Even when a physician finally tells a patient that there is nothing to worry about, there can be lingering concerns, feelings of insecurity, and distrust of the medical system. These are difficult to measure, but very real consequences. We each hold a responsibility to remember our patient's stories, to picture Peter and his parents, and throughout our career use the capabilities of, but not get lost in, the medical-industrial complex.

Toward the end of our conversation, Peter's mother responded, “Thank you . . . this really, really helped us.” The irony in her words still jars me. My initial plan for Peter involved several tests and examinations, pushing them further down a painful path. However, what was needed was someone to listen thoughtfully and be present with him and his parents—what I have come to call the “hear and now.” No tests, no procedures.

Dr Wilbourne turned to me and said, “Learning how to consolidate clinical information takes time. But you recognized the tense emotion Peter and his family felt during this visit. Sometimes, diagnosing that is just as important as the medical problem. And it is often harder to teach.”

A nurse knocked on the door. “I repeated Peter's postvoiding residual; it's less than 10 mL.”

References

1. Relman AS. The new medical-industrial complex. *N Engl J Med*. 1980;303(17):963–970.
2. Orme NM, Fletcher JG, Siddiki HA, et al. Incidental findings in imaging research: evaluating incidence, benefit, and burden. *Arch Intern Med*. 2010;170(17):1525–1532.
3. Bryan CS. What is the Oslerian tradition? *Ann Intern Med*. 1994;120(8):682–687.



Ambar Mehta, BS, is a Medical Student, Johns Hopkins School of Medicine; and **Edward J. Wright, MD**, is Chief of Urology, Johns Hopkins Bayview Medical Center.

Corresponding author: Ambar Mehta, BS, 1919 East Pratt Street, Baltimore, MD 21231, 954.319.7220, amehta25@jhmi.edu