A Clash of Cultures

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For several years now, I have watched the building of a Clash of Cultures between the young and the old that has now also spilled into the doctor's office and medical examining room.

I was recently bruised myself in this clash, I suppose, prompting this essay.

Partly the Clash is a creature of modern technology, but deeper than that is the impact of technology on our younger generation, which we call the Millennial. They seem to expect instant gratification and a serene life. Even Amazon advertises on TV to expect your delivery by truck the next day or by drone that afternoon, after just one click on what you want.

Of course, I realize the young and the new culture will win as old guys like me fade away.

So … I suggest some rules or guidelines or explanations to ease the Clash, at least in the medical office of older physicians like myself.

Here goes:

>> Be happy. Or at least don't be sour. Of course, we physicians fully understand the frustration and agony of disease and human frailty. But remember, we did not cause it or bring it on. Your illness is not our fault. Hopefully we can help, but even then, we can sometimes only help in part. There may NOT be an instant fix or cure, and if we say "so," we are not being mean or angry.

>> Leave the cell phone and "blue tooth" outside. For older doctors like me, the cell phone is an abomination in our medical exam rooms. They are distracting and rude. We want you to talk to us and to engage with us, not a computer chip. Moving back a patient's hair one time, I joked about the thing sticking out of her ear; she did not think I was very funny. At least turn them off, PLEASE.

>> Understand the new privacy laws. Like it or not, doctors are now required by law to know who you bring into our exam rooms with you: their names, their age, their relationship to you and whether they have your permission to stay or not. AND we are required to note all of this information in the medical record to avoid severe penalty enacted by the government. We are not being rude or mean.

>> Demographics. The new Electronic Medical Record now required by law insists that we have your full demographics, as do the insurance

companies, if we are going to get paid. The exact spelling of your name, your middle initial, your pharmacy and your personal or referring physician; insurance companies require that these physicians be currently licensed and currently practicing physicians. These questions are not a test or a challenge to you; they are a necessity for us.

>> The Chief Complaint. Insurance regulations now require this information. Again, this is not a challenge or test to you. We need to know for both ourselves and the insurance companies. We do not want to hear a speech about your self-diagnosis, although we do listen to the patient. Just tell us “I have a headache” or “My left foot hurts” or whatever. We don’t need a speech.

>> The Medical History. Then most physicians will ask a lot of questions, because at least in our referral practice we do not know you and we need to know the answers. These questions are not an assault on you or a test or a challenge.

>> The Physical Exam. Yes, Virginia, we still examine patents, even the young physicians, although in medical school students now have to examine dummies or computer models because of legal threats. I usually make comments during my exams or even ask some more questions. The experienced physician with good intuition can do a thorough exam quickly; in fact, with a close look and a two-hand grasp, he/she can tell much about your body and organ function in just seconds. We examine for two reasons: 1) to know your body and general health; and 2) to look at the area that is bothering you. If the patient is seeing me for a skin problem and wearing body jewelry, now more and more common, I will insist they remove it as soon as they can because of potential remote effects, as just one example of a comment during an exam.

>> The evaluation or workup. Here doctors differ, depending on specialty and function. The family doctor, once he knows you, will usually stick to the primary complaint, but somebody like me will do more. For example, in my field, if someone comes in with difficult-to-treat asthma, I would typically do the following: make sure I think the current medicines are proper and at proper doses; make sure you are using the medications properly; look for causes of difficult-to-treat asthma like allergy, stomach reflux, unsuspected sinus disease, heart trouble or other lung disease; or maybe you really don't have asthma at all. Since half of our patients come from more than an hour away, we are thorough on our evaluations and often do much at the first consultation.

>> Treatment. We hope for a specific diagnosis, and then we aim for a cure, but many diseases are not curable but hopefully controllable. And in my field, many syndromes do not have a specific cause or diagnosis but are because you are human, and these things happen to some humans. I am not ignorant or being mean or angry when I tell you all of this. Most doctors start with the simple therapy to see how it works over a few weeks or so, because we can add more therapy as we go along. OR if your symptoms are severe, we often do just the reverse: start with maximum therapy to get you better, and then reduce treatment to a lower level later as you improve.

Let me know what you think.