

# Comment From the Editors

## Challenges in the Physician-Patient Relationship: Feeling "Drained"

On occasion, physicians who care for patients with chronic or functional gastrointestinal disorders may feel "at odds" with the interaction. As a consultant who receives physician referrals for difficult-to-manage problems, I have learned that comments such as: "This one is right up your alley," or "I hope you can help; I've done all I can," often speaks to the physicians' feelings of frustration when unable to help their patients. Recently, I was supervising a fellow who saw a patient referred to us for some challenging management issues. After the interview, she noted how "drained" she felt, and maybe it was because of being up on call most of the night. But then on another week, she saw a different patient with (at least to me) an equally challenging management issue, yet this time she seemed more invigorated and interested in the issues at hand. Was it the full night of rest the night before, or something else? So I asked: "What makes some patient visits feel so draining?"

After some reflection, she mentioned what came to mind (presented in order): "(1) If I don't have a clear idea of the problem, (2) if patients have more complaints than I think I can handle, especially if there are other demands on my time, (3) if the type of requests are hard to meet, and (4) if critical comments are made (e.g., 'I'm not doing something I should be doing, and sometimes I take that personally')." She added: "All of this can make me overwhelmed, like I can't do anything to help. Eventually, I start to feel like a failure."

As physicians, we are committed to care for the patients who come to us. Yet we all have certain interests, expectations, and needs as caregivers. The degree to which they are

met will affect our attitudes and behaviors in administering such care. So, I believe that with more challenging (i.e., "draining") clinical situations, the fellow's reflective comments highlight personal expectations not achieved: (1) To make a correct diagnosis, or at least understand the problem, (2) to help the patient to get better, and (3) to obtain gratification (and even be thanked) for having done a good job, or at least not criticized. When none of these eventualities occur, in the least we become dissatisfied, and at worst, we may question our competence, and even blame or stigmatize the patient. I believe the challenge to handling these situations does not rest with the patient, but with how we understand our role in this physician-patient interaction, and how we respond in a manner that is helpful to the needs of the patient. Let's consider these 3 issues:

1. Traditionally, making a correct diagnosis is considered intrinsic to our role as physicians—a measure of competence and skill. This became evident to me several years ago when as a visiting professor at a major medical center, the residents presented a patient with undiagnosed chronic abdominal pain. They discussed their inability to help, and their feelings of ineffectiveness that led to blaming the patient for "bothering them." I asked: "How would you feel if on the next visit you make a diagnosis of pancreatic carcinoma?" One resident heaved a sigh of relief and (with the approving nods of the others) said: "Better. At least I would have a diagnosis." The personal meaning of making a diagnosis became clear to the group when they realized that the patient would surely die.
2. Helping the patient get better (and hopefully to "cure") is a valued expectation, yet when illness becomes chronic, cure is unlikely and improvement comes slowly, if at all. So we need to reset our expect-

tations (i.e., "lower the goal posts") from diagnosis and cure to improvement in function and other achievable outcomes (e.g., partial reduction in symptoms, improved social functioning). Although all patients want to get better (or cured), they also recognize that many illnesses are chronic, disabling, or life threatening. Here, the studies show that patients want to be heard and understood, to be given information, and to not be abandoned.

3. Feeling gratified in work motivates us and improves our well being. In fact, it is difficult to carry on if we feel ungratified, ineffective, or worse, criticized for not doing our job effectively. I believe the problem here relates to the unrealistic expectations we set for ourselves, and at times the guilt we feel for occasionally harboring negative views toward patients. It is okay to feel frustrated or even angry, at least initially. We are not accountable for our thoughts, but for our behaviors. In time, as we begin to understand the issues leading to these feelings and reset our personal expectations, the negative feelings dissipate. Gratification comes not only from diagnosis, but also from an understanding of the problems, and not only from cure but also from setting a realistic course of care. I have seen fellows and residents become quite satisfied when they are able to elicit that the patient's previously puzzling demands for a colonoscopy relates to anxiety because a relative recently died from colon cancer. Or when the patient returns for a visit stating that the pain is still there, but they are now learning how to manage it better.

Finally, it helps to understand which patient behaviors occasionally seen in practice lead some physicians to feel "drained." This may occur when a patient sets high expectations on the physician to make

them better, or frequently contacts them with requests that are difficult to solve. Experience suggests that such patients may be responding to their own feelings of ineffectiveness for not being able to manage their illness, and this may generalize to feeling not in control of their lives. So the expectation for care is off-loaded to the physician. Here, our job is not to pick up an unachievable burden of responsibility for the patient's care, nor push it back to them ("you'll have to learn to live with it"), but to share the responsibility to

achieve realistic goals. We want to facilitate a process in which the patient can regain self-esteem by not viewing themselves as weak or as a failure for having these problems. We can accomplish this by validating that these feelings are legitimate, and then help the patient to regain control (and self-esteem) by finding ways for them to learn to help themselves, as we work to reduce symptom distress, and provide support and hope. We also must be clear on our expectations for providing care in a time-efficient manner: to work

from priorities rather than address all the problems, and to establish regular brief visits over time. As long as the commitment exists to work with patients, they will not feel abandoned and will thank you for the effort.

DOUGLAS A. DROSSMAN  
*Associate Editor*

The author thanks Michelle Thiny, M.D. for her personal contribution.

---

doi:10.1053/gast.2001.28976

## ***Kussmaul Who Pioneered Gastrosocopy***



Copyright holder unknown. Photo obtained from the National Library of Medicine Website (<http://www.nlm.nih.gov>).

Adolf Kussmaul (1822–1902) was born at Baden, near Karlsruhe, Germany. Both his father and grandfather were military surgeons. He was active in student affairs at Heidelberg, then extended his medical studies at Vienna and Prague. Four years of satisfying rural practice ended with a devastating bout of paraplegia, possibly Guillain-Barré polyneuritis. The cruel blow may have been a blessing in disguise, for after a prolonged recovery he became a protégé of Virchow at Würzburg, where he was awarded his M.D. degree in 1854. Kussmaul is probably best remembered for his description of labored "air-hunger" breathing in diabetic acidosis. He also described periarteritis nodosa and pulsus paradoxus, as well as demonstrating the value of thoracentesis in empyema and pneumothorax and devising a stomach pump for gastric lavage. At Erlangen in 1868, Kussmaul devised the first gastroscope, a straight rigid metal tube passed over a previously inserted flexible obturator. He must have considered his original experiments with gastroscopy as trivial and impractical, for he never mentioned the work in his own publications; we know of this effort only through the writings of others. Kussmaul was elected an honorary member of the AGA in 1901.

—Contributed by WILLIAM S. HAUBRICH, M.D.  
*Scripps Clinic and Research Foundation, La Jolla, California*