

Virtual Mentor

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MEDICAL NARRATIVE

Physician Self-Disclosure and Patient Counseling

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As I looked at the monitor, my eyes filled with tears: cervix measurement—6 mm. I knew what that meant because I had been here before. That time, I had been 18 weeks pregnant with a short cervix and it was a sad ending. This time things looked worse. My cervix was shorter and I was carrying twin A and twin B. My blur of tears was interrupted only by the nurse taking vital signs and bad television.

“No, I don’t want visitors.”

“No, I am not interested in a support group.”

“Sure, the chaplain can come by, but to what end? God clearly does not want me to be happy.”

And I am sure I thought and said many things that were more heretical than that.

Then everything changed. On hospital day 3, my obstetrician looked at me in exasperation and said, “Look, Ms. Doom and Gloom, if hope and prayer work for cancer, what makes you think they don’t work for pregnancy?”

Lying there, I had plenty of time to think about what he had said, and slowly I began to agree. Instead of approaching my situation with fear and inevitability as I had last time, maybe I should try hope and positivity. Of course, I was still realistic about the possible outcome, but I dared to hope that this time it would be different. I requested a calendar and marked off each day. Twin A and twin B became Camille and Kingsley. I celebrated their every movement and the differences in their personalities as I perceived them. I looked at baby furniture (thanks to Wi-Fi). I built a wall of positivity around me. The only people I let know I was in the hospital were those who could help me maintain that wall.

As for the doctors? No matter what words emerged from the lips of some of them, their eyes spoke volumes of pity. When it was time for those pitying physicians to round, I pretended I was asleep. It worked only 60 percent of the time but it was worth the gamble. And slowly the time did go by. I met the viability mark and made it to 25 weeks before the twins needed urgent cesarean delivery. Some were sad for us. But my husband and I were elated because this time, unlike the last, we had a fighting chance in a NICU that boasted an 85 percent survival rate for babies the gestational age of our twins.

It goes without saying that my time in the hospital changed my understanding of the patient's experience. And it complicated the day-to-day challenges I face as a practicing perinatologist. Over time, I have changed my approach to some of these challenges, particularly to two of the most common and obvious: physician self-disclosure and patient counseling.

Physician Self-Disclosure

Because the predominant feeling I had during my hospitalization was one of extreme loneliness, I vowed always to be open about my experience to patients. My physicians admitted that going through the experience with me made them more empathic and taught them a lot about what a patient goes through. Eventually, though, I discovered the difference between "openness" and physician self-disclosure. Physician self-disclosure has received mixed reviews in the literature. While it may improve patients' perceptions of surgeons, it may not do the same in the case of primary care physicians [1]. An investigation that was part of a larger study of patient communication and health outcomes funded by the Agency for Healthcare Research and Quality actually suggested that physician self-disclosure might be disruptive. One hundred primary care physicians agreed to accept two unannounced and secretly recorded visits by people trained to play patient roles. Of the 113 transcripts reviewed, 34 percent of the visits contained at least one self-disclosure. None of the self-disclosures was patient focused, while 60 percent were physician focused, the investigators concluded. Eighty-five percent of the disclosures were considered not useful and 11 percent were viewed as disruptive [2].

It is difficult to predict the impact of physician self-disclosure on a person confronting the shock of an abnormal pregnancy. Initially, I thought, like many physicians, that it was a way to enhance the patient-physician relationship. I have since reconsidered. In delicate situations I now believe that self-disclosure can be harmful and disruptive. It can draw attention away from the patient just when the patient needs that attention most. When a patient asks about my personal experience, the pause during which I have the internal conversation about whether to lie or tell the truth invariably speaks volumes to the patient. A decidedly poor liar, I often abbreviate the truth and try to redirect the conversation toward the patient. And in those moments I long for the days when my answer was, "No, I have never been pregnant."

Patient Counseling

When counseling patients about possible outcomes and therapeutic alternatives, it used to be easy to quote a low rate of intact survival rate for prematurity at the limits of viability—(23-25 weeks). It is more difficult now that I no sooner put my bag down in the front hall than the twins come running up to hug me. And yet, providing statistics is what I have to do and I do it. Counseling affects patient decisions, and it is critical to do it in an unbiased way.

On the other hand, physicians' attitudes have been shown to affect both the probability that an intervention for fetal benefit will take place and infant survival [3]. I don't take this lightly. I still provide the facts and statistics. I still ascertain parents' understanding of the facts. But then I ask them open-ended questions about their thoughts and take cues from them. For those who need more medical facts and information, I provide that. But there is another subset. It is the group that wants hope. Often it is a patient who has been down this path before. For her I am willing to offer hope. Not false hope. Directed hope. It can be hope that her fetus will make it to viability, or that her infant will do better than expected. It might be hope that she will one day heal from this experience or that she will bond and enjoy the time she has with her child. Some are able to celebrate their infants while they have them; to name the child and collect ultrasound pictures. After all, if you thought another loved one was going to die soon, isn't that what you would do?

The challenges continue and my response to them continues to evolve. Overall, I believe my experience has made me more sympathetic to patients with pregnancy complications and has helped me anticipate some of their questions and fears. But their experiences are not mine. What I say to each must serve her needs, not mine.

References

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