Academic Psychiatry (2024) 48:292–293
https://doi.org/10.1007/s40596-023-01853-y

THE LEARNER'S VOICE

The "Right Thing" to Say

Nam S. Hoang[1]

Received: 10 July 2023 / Accepted: 16 August 2023

There were twelve of us medical students in a dimly lit conference room. Our doctoring tutor roleplayed with us one by one as we practiced how to say "no" to patients. It was my turn and I sat to face him. Up close, he had a sly grin, the many of wrinkles of his face suddenly looking like an endless pattern of smiles and frowns. He was a man of a thousand unreadable expressions. As my foot tapped on the tile floor, the creak from my rickety chair followed with a split-second lag. Behind me, eleven pairs of eyes trailed the bead of sweat rolling down my neck.

"Well, sir," I said. "I can't prescribe that. Opiates can be addicting and I'm concerned that—"

His voice boomed in that little room. "You think I'm an addict? What about my pain?"

Stunned, I moved my jaw aimlessly, no words coming out.

He chuckled. "Try this. That medication can make you constipated and sedated and can even make it difficult for you to get an erection. I couldn't in good conscience prescribe something I knew would harm you. But how about a medication that can reduce your pain without those side effects?"

It was my first semester of medical school and with a consternated expression, I asked, "How was I supposed to come up with that?"

Throughout medical school, the most intangible skill we tried to learn was knowing the right thing to say. It could not be mastered in the same way as medical knowledge, through flashcards, lectures, and practice problems. It had to be learned through modeling, role play, or passed along like gossip. At the time, I viewed it as the perfect sequence of words, in just the right combination, for a given situation.

So, I began to pick up phrases from my residents and attendings. I noticed nurses were particularly savvy when it came to tiptoeing around difficult requests. Even listening to conversations between patients and their families could lend a useful phrase. At one point, I picked up a trick I was told to never use: "I'm not sure if your insurance will cover it."

"Don't say it if it isn't true," one attending told me.

Years later, as a sub-intern on a psychiatry rotation, I encountered a man whose perseverance regarding benzodiazepines was nothing short of frightening. My fingers were clacking away at the keyboard as the patient recounted the story of his car accident 12 years earlier and the anxiety and pain that followed. The smell of coffee from the workroom pervaded even to this far corner of the hallway in the last clinic room, where we sat facing each other under bright fluorescent lights. Through a nearby window, the setting sun, as well as my sagging eyelids, signaled the approach of the day's end.

"—I know my dose is already high but I need more."

I froze. The sound of clacking keys was replaced by his ragged breathing.

My mind flashed back to that conference room. "I'm concerned about the side-effects—"

"There are no side effects for me," he exclaimed. "I've been on them for years."

I grappled for another line. "I couldn't in good conscience—"

"Do you even have a conscience?" He was so angry he was spitting. "I need a higher dose. How can you just ignore me?"

Finally, though I am not proud of it, I blurted out, "Your insurance wouldn't cover it."

He froze, then stuttered. "H-how much would it cost?"

"I don't know. But let's not find out."

As I walked out of his room, I felt shame wash over me. I tried to rationalize that ultimately my actions were good for him. I weighed the moral objectivism of lying as a universal fault versus the consequentialism of bettering this man's health. Ultimately, I realized, I was intellectualizing my guilt as a way to cope with it, that really, my lack of skill in handling this situation led to an ethical breach in this patient's care.

✉ Nam S. Hoang
dannyhoangn@gmail.com

[1] UCLA David Geffen School of Medicine - University of California Los Angeles, Los Angeles, CA, USA

After I confessed to my attending, he sat down with me and the patient.

"Finally! A real doctor," the patient said.

My attending clarified that the patient's insurance coverage was not an issue. He cited and explained numerous studies. He asked questions, told stories, and prompted the patient to consider his dependence and his motivation to stop. It was simply masterful to watch.

Yet, the most striking moment occurred after we walked out of the room. The attending pat the patient's back and gave him a reassuring smile. They shook hands and shared a moment of silence, their hands like conductors, a current between them.

The patient said, "Thank you." His voice had gone soft.

My attending nodded. "Of course."

The language was simple, the phrases automatic, but the emotion was built, the intention nuanced, and the trust earned. It dawned on me that the right thing to say was not a computational problem, solved through a thousand iterations resulting in the phrase with the highest success rate. It was not just one moment of silence shared, but a multitude of gestures and micro-decisions throughout a conversation, that accumulated and evolved into a powerful current of shared intention.

Later, at my workstation, I found that my attending had printed one of the studies he cited to the patient and left it on my keyboard. It reinforced that there was no fast track to saying the right thing. At every stage of my clinical training, I have reflected on my lack of fluency in providing reassurance. However, I am learning that fluency is not a destination, not words in isolation, but a life-long journey in recognizing and responding to nuance. For language is evolving, and social constructs are, too. New studies and medications emerge each day. The ability to counsel, console, and reassure—there is no end point. And each patient interaction is not one iteration to test a phrase, but a thousand little moments to learn from.

Declarations

Disclosures The author states that there is no conflict of interest.