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My Mother, A Professional Patient

When a physician's aging mother starts visiting lots of specialists and often being unsatisfied with the results, the son comes up with a clever, life-enhancing solution.

BY STEVEN A. WARTMAN

IF YOUR MOTHER IS ANYTHING LIKE MY MOTHER, this will make perfect sense. Shortly after becoming a widow fourteen years ago, my now eighty-eight-year-old mother began to progressively increase her schedule of doctor visits. She lives alone in a large apartment in Philadelphia, while I, a physician and her oldest son, throughout my career have lived and worked several states away. Despite—or perhaps because of—this, in recent years the number of phone calls from my mother about her medical care began to increase, with requests to find her a doctor, call a doctor for her, get her an appointment, change her appointment, cancel her appointment, and reschedule her appointment, as well as questions about whether she should take certain medications or have specific tests.

In my efforts to help her, at times I felt that I was well on my way to wearing out my welcome with the bulk of physicians in Philadelphia. Indeed, she was seeing a seemingly endless progression of specialists—some new, some old, and some recycled. As best I can recall, they included internists, cardiologists, dermatologists, neurologists, ophthalmologists, rheumatologists, orthopedists, gynecologists, urologists, otolaryngologists, plastic surgeons, oral surgeons, neurosurgeons, endocrinologists, and gastroenterologists (I've probably overlooked a few). Furthermore, with a few notable exceptions—such as with her general internist—my mother rejected much of the advice these physicians gave her or, at best, grudgingly agreed. Basically, if my mother didn't hear what she wanted to hear, then off she went to another doctor. And speaking of hearing, my mother has had what she considers to be an ongoing battle with hearing aids; the problem is that she hears better without them.

The truth is that my mother does have an assortment of medical problems, some serious, some not. Yet the real reason for her frustration was that no physician was able to make her feel the way she felt, say, ten, twenty, or even fifty years ago. I was frustrated, too, and was becoming increasingly uncomfortable at using whatever academic title I held at the time to gain her access to busy practicing physicians.

Sometimes I was amazed by my mother's reactions to her medical problems, ei-

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ther real or perceived. Last year, for example, while running to catch a bus, my mother fell and broke her nose. Visiting her shortly afterward, I managed to get her an appointment with a well-known ear, nose, and throat specialist. I went with her to the appointment, and I thought the doctor did an exceptionally good job of examining her and talking with her. After he pronounced her to be doing well and not needing any further interventions, my mother suddenly announced that she wanted a "nose job" to fix the almost-imperceptible bump the fall had caused. The physician was taken aback (as was I), and he suggested that my mother and I talk about it. Later that day I said, "Mom, do you realize what a nose job involves? They'll need to put you under general anesthesia to fix this minor cosmetic problem."

"I don't like the way this looks," she replied.

Finally, after much back and forth, I put my foot down and told her that I could not recommend that she have that kind of surgery.

"OK," she said. "You call the doctor and see what he says."

When I spoke to doctor on the phone and expressed my opinion, he sounded relieved. "I was really hoping you'd tell her that," he said.

I've spent most of my career in academic medicine, immersed in medical education at one level or another, but even so it took some time for me to come up with a solution that—almost overnight—made both my mother and me less frustrated and perhaps even a bit more comfortable with her life and medical situation. I called someone I knew at a medical school in Philadelphia and asked if the school had a certain program. "Certainly," was the reply. Then I asked how my mother could interview for it.

Getting With The Program

In recent years the nation's medical schools have been moving toward a new type of education model that uses trained participants to portray specific kinds of patients. It's not a new idea—indeed, the use of "standardized patients," as they are often called, dates back in some medical schools for twenty, thirty, or more than forty years. The concept is straightforward: Medical students can learn important interviewing and physical examination skills from individuals playing the roles of patients. The standardized patients whom they examine are trained to give the students feedback (as do faculty members who observe the interactions). What is relatively new is the body of evidence showing that encounters with standardized patients are valid and reproducible from a testing and evaluation viewpoint. Simply put, it's an effective education tool.

The use of standardized patients has been greatly accelerated by the confluence of two major trends. The first is the overdue realization that the traditional education of medical students had relatively little curriculum time devoted to the fundamentals of basic doctor-patient relationships. Skills involving communications

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with patients and developing the broad array of skills that make up a good bedside manner weren't taught in a way that could be measured, tested, or evaluated. Because of this, it was difficult for students to receive targeted feedback in these important areas, feedback that could go a long way toward improving the way they eventually delivered patient care.

The other trend is an ethical one. The long-time traditional method in which medical students initially learned from encounters with actual patients needed to change in light of views on patient safety and privacy. Rather, students should first encounter people who are playing the roles of patients, thereby providing the students with early learning experiences that allow them to make mistakes and practice their skills.

The use of this new education model was greatly increased in 2004 when the national organization that offers standardized tests to medical students (the board exams) added a new clinical skills component. Passing board exams often is a requirement for graduating from medical school, and, in any case, the exams must be passed to receive a medical license to practice. So when the clinical skills component was added to the board exams, medical schools responded with enhanced education and training in that area, training that focused on doctor-patient communication skills, basic physical diagnosis, and clinical reasoning.

Medical schools frequently house these new (or modified) programs in on-campus clinical skills centers consisting of ten to twenty specially constructed examination rooms equipped with digital cameras that are linked to a central monitoring station. Carefully designed "patient protocols" are developed so that medical students can interview actor-patients who present with specific standardized medical problems. The students then conduct limited physical examinations and summarize the findings, all in a relatively short period of time. These protocols allow staff members at the center to evaluate students' skills in communication, physical examination, and diagnostic reasoning.

Central to these programs is the critical need to hire and train a variety of people with some ability to act—or in some cases, professional actors—to play the standardized patients. Ideally, the people portraying patients represent broad population groups by age, sex, and ethnicity. All of them learn the roles they will be playing and what the medical students are expected to do during the encounter. It has been well documented that they master the art of playing real patients, whether, for example, it's a young male complaining of back pain, a middle-age female with chest discomfort, or an elderly patient who has difficulty concentrating.

Following an encounter with a medical student, a standardized patient completes the second part of the job: providing feedback using a checklist—and often on a computer—about how well each student performed. The feedback includes comments on the medical student's communication skills, physical exam techniques, and overall approach. In addition, the staff members at the center review the tapes of each session and provide additional feedback and evaluation. The pro-

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cedures parallel the formal testing that students undergo when they take the clinical skills part of the national board exam.

A study published in 2005 pointed out the dramatic advances the nation's medical schools have made in using standardized patients. A survey of deans at about one hundred medical schools documented that schools are increasing the curricular time and teaching resources devoted to such programs.

Why Not Mom?

Which comes back to the insight I achieved last year: My mother had become, in a real sense, a professional patient. My epiphany was that there might be an opportunity for her to be employed in that role. It turns out that the local medical school I called was looking for older people (termed, of course, "geriatric patients") for their standardized patient program, and they were willing to interview her for the job. I encouraged her. With a bit of trepidation, my mother took the bus to the school for the interview. I felt that she would be ideal for the role. She's always been a bit of a thespian and enjoys the theater. She taught school in the past, served for many years as a docent for local art museums, and occasionally participated in local productions put on by various organizations to which she belonged.

After the interview, she called to say that the people were very nice, but that she was concerned about learning the various patient roles and the medical terminology, as well as whether she had the ability to operate the computer she would need to use to evaluate the medical students. I continued being encouraging. Eventually she was hired and became increasingly excited about reentering the workforce.

Following an orientation period, my mother began to tackle and learn the various roles she would play: a patient with congestive heart failure, a patient with joint pain, and so forth. She loved learning the terms and the techniques used in physical examinations, and she especially liked the opportunity to give students feedback on their interviewing skills and beside manner. When she was a real patient, my mother often complained that the doctors didn't explain things well, or didn't seem to care enough, or didn't take enough time with her. Now, as a professional patient, she had the opportunity to set future doctors straight. She also quickly mastered the computer-based student evaluation system.

Six Months Later

During a recent visit to her apartment, my mother insisted that we go over the script she was learning for an orthopedic examination where the medical students were expected to test her joints using various techniques. As an internist, I wasn't familiar with several of the methods and the signs that they were supposed to be able to elicit when examining the patient. I

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found myself in the interesting position of having my mother explain what she understood them to mean. Not only had my mother become a professional patient, she had become a teacher, imparting information to medical students and to me as well.

When I asked my mother how she felt about her new role as a standardized patient, she promptly informed me that she preferred the term actress-patient. (She's always had strong opinions.) She told me that she'd learned so many things that she had never known about, such as how a doctor should come in to see a patient, wash his or her hands, and use the patient's name frequently. She is amazed at the amount of material medical students need to learn and how much "help" they need in applying what they've been taught. She loves the part where she gets to talk to the students after the session to give them her feedback. Although she tells the students where, in her opinion, they need to improve, she tells me that she is also mindful to give them positive feedback as well. She notices how nervous they are, and she often tells them to smile and lighten up. She's proud of learning to use the computer and how to evaluate students properly. She's become comfortable in front of a camera (it's even something that she now enjoys). And, she told me, "The pay is good."

"My mother's frustration with aging, and all that it involves, is being channeled into a productive, late-life mini-career, one that is at the cutting edge of medical education innovation."

My mother also believes that her actress-patient experience has changed the way she views and interacts with her own physicians. She now notices the differences between what the medical students are taught to do and what her doctors actually do. She's more alert and knowledgeable. She says she'd like to spend more time working as an actress-patient; she recently asked if I knew of other medical schools in the Philadelphia area that were hiring.

Despite an array of medical problems, at eighty-eight my mother is in relatively good physical health. But her life, like that of so many retired, aging people, to a large extent had begun revolving around ideas of declining physical and mental capacity. Many of her contemporaries have passed away or have become increasingly incapacitated. Now, with this new job, she feels that she is making a contribution and that she has a purpose and mission to fulfill. For the time being, my mother's frustration with aging, and all that it involves, is in part being channeled into a productive, late-life mini-career, one that is at the cutting edge of medical education innovation. In becoming a professional patient, my mother has the best of both worlds: She's teaching others while still learning herself.

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