Think Before You Think

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Think Before You Think

Christopher Monson

I’ve noticed a change in the way that I think, and I’m not sure if I like it.

I’ve started wanting a history and physical on my friends and relatives. Now, I don’t mean that I literally want to peek into their medical records; it’s more that I have come to expect a certain amount of background information before addressing a problem. When I’m asked for advice by friends or family, I go into “doctor mode” and immediately want more information than it’s socially acceptable to ask for.

One of the most important things we learn early in medical school is that our ability to diagnose and treat is most directly affected by the quality of our history and physical. You can’t rule out or rule in anything if you don’t have all the appropriate information. That quick and easy discharge could be deadly if you forgot to ask about an overseas trip, or those unrelated headaches, or that growing depression. Doctor-patient privilege is a powerful thing, allowing you to ask anything—with the understanding that the conversation is confidential, useful, and may help to solve the problem at hand.

I want that same ability for certain situations. I want to be able to call “timeout!” on normal relationship dynamics and deploy this higher standard of listening, but that’s just not socially feasible most of the time. If a friend is asking about their knee pain or Uncle Joe wants you to look at a rash, you can ask whatever you want. But with interpersonal problems, issues at work, or in academics, there is a level of discretion employed that you simply get to bypass in medicine. Or, at least, that’s how it should be.

I have found that, as my clinical reasoning skills have (slowly) grown in medical school, my ability to turn off that part of my brain has diminished. If a friend is asking for serious non-medical advice, I go into “problem solving mode” (a close relative of “doctor mode”). It’s fun! It turns even terrible situations into puzzles. If I can just see all the pieces, eventually I will solve it. But this is a false analogy. There are times when the broken pieces will never add up to a full picture.

For years we are trained to elicit a problem, break it down into useful pieces of information, elicit more info if needed, and then start offering solutions. That’s great, usually. But in real life, we aren’t hearing the problem from an exam prompt or even a patient in a clinical setting. These everyday questions come from friends, from family. They probably aren’t telling you their troubles because you’re a doctor or medical student, but because you are a person close to them who they can trust to listen and reassure them. Sometimes they already know the answer to their problem. Sometimes they aren’t sharing everything because the problem is too personal and you figuring out the solution (using your mighty problem solving skills) will only bring more pain, not less.

Our zeal to diagnose and treat our patients’ physical problems can cause injury if it goes unchecked, as with radiation from CT scans or a C. diff infection from unnecessary antibiotics. I think we sometimes forget that we can also violate that Hippocratic principle of “First, do no harm” merely by losing sight of the person for the problem. Sure, we probably have the ability to poke and prod a friend’s difficult story for our own better understanding, but is that what they actually expect from us? Occasionally, they might. But often, I’d wager, all they truly want is an active ear and sympathetic nod. Sometimes having a skill is not as important as knowing when to use it.

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To any med students reading this, try to keep in check the wonderful, powerful ability you are honing to someday save untold lives. Your ability to problem solve is part of what makes you special and able to apply the vast knowledge you are accumulating, but it also can isolate you from your fellow humans if you let it dominate your thought process.