HEALING ARTS

Materia Medica

The Parallels between Parenting and Patient Care

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Soon after my medicine residency, while on faculty at a large academic medical center, I crossed paths with a complicated patient. Middle aged, homeless, and struggling with substance abuse, he was as well known to the staff for his disruptive behavior as he was for being discharged AMA. His behavior continued after he was admitted to my inpatient service for alcohol withdrawal. Late Friday afternoon, his nurse called me, distressed. "This patient needs to be transferred off this unit. He's just too disruptive." Shortly thereafter when I arrived on the floor, he was at the nurses' station, stumbling and screaming to be discharged. He was largely incoherent, unable to reason, and it became clear relatively quickly that he lacked decisional capacity to choose to leave the hospital. During our discussion, though he continued to yell, I remained calm and even-handed about how we were going to care for him. I told him why he was here, sick in the hospital, and I listened to his frustrations about the staff, his room, and the food. The entire encounter, which ended amicably, lasted about 5 minutes. As I left him and returned to the nurses' station, his nurse came up to me and said, "You handled that so well. How come you didn't get angry?" And I said "I've seen worse. I'm a parent."

It does not escape me that a literal interpretation of *acting* like a parent to a patient is to act "paternalistically," a position not generally ethically supportable. Furthermore, I don't intend to imply that patients all behave like children (except of course, the ones that *are* children), but rather that some principles that are operative with parenting may have a place in clinical care and vice versa.

How then are parenting and doctoring similar? What are the skills that both parents and physicians develop in common in their *practice*?

The centrality of the relationship.

The act of being a physician and parent is in very important ways, defined by its *relationships*. In both, each party learns from one another, grows alongside each other, trusts and even *believes* in one another. To the physician, it is this attention to maintaining the therapeutic alliance, that we understand to be an integral part of the healing process¹. To the parent, the relationship is what makes for a family.

Ensuring that relationships grow and remain strong takes work and occasionally means relinquishing control. Becoming comfortable and effective with my patient's problems means learning to manage my own biases and emotions so that I can focus on his problem, not my own. A patient's noncompliance tells me I need to work harder to adapt and accept what may be beyond

my ability to control, not that patients have to bend to my medical advice because I say so. Similarly as a parent, watching myself become increasingly and visibly frustrated when my daughter prefers jumping on our bed rather than getting dressed for school has reminded me that if I want to change her behavior, I'll be more successful if I start with managing my own negative reactions.

As both a parent and a physician I am aware that although I often possess more power in my relationships with my patients and my children, I've recognized that it means very little if I cannot build the trust needed to strengthen the relationship. No one benefits when my advice, however well meaning, goes unheeded because it is delivered as a directive. Astute physicians and parents alike know that when making decisions about those we care for (literally and figuratively), attempting to level the playing field and maximize the involvement of other party prioritizes the importance of the relationship over the content of the conflict.

Listening as a critical learned skill

For parents and physicians, listening allows for important stories to unfold. When I invite my patients to articulate their thoughts and fears, I can then manage both the clinical problem *and* attend to the concerns of the patient, which more often than assuring the diagnosis, is associated with improved patient satisfaction^{2,3}. When I pause while taking a patient's history and ask "What do *you* think is wrong?" I'm afforded an opportunity to hear the patient's "explanatory model," for what they believe is happening to them, and sometimes what most concerns him⁴. My patient described the onset of his illness like this: "I developed diabetes after I had been eating too much sugar for 3 months after my brother died. I think all the stress had something to do with it." While I may respond with a pathophysiological description of diabetes (i.e. islet cell dysfunction coupled with insulin resistance) and my patient may agree, starting with and privileging the story I have been told adds value to our relationship because it is *the patient's* story—one that permits some perceived control of an illness that may at times feel beyond their understanding⁵.

I've noticed that when I respond to my children's questions with "Well, what do *you* think?" an analogous process unfolds. Rather than answering their question straight out, pausing to hear how they respond to my question often yields a better appreciation of what they are asking⁶. Inquiring of children allows them to be the rightful source of their growing

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knowledge of the world and permits them to become an authority of sorts whose opinion is respected—qualities patients desire as well. Sometimes though, it simply allows clarification so that the proper question can be answered. At age 4 my son asked me, “Dad, who created the world?” As I paused to consider how best to answer such a lofty question, I asked him, “What do you think?” and he responded with “What does ‘create’ mean?”

Empathy

In learning how to elicit and empathize with the feelings of my patients, I have gained a greater appreciation for recognizing and acknowledging my children's feelings⁷. When he was very young, my son, in spite of the age old admonition, would sometimes (literally) cry over spilled milk. The days were long back then and occasionally my response was not the most empathic. But watching tears well up in my son's eyes meant he was hurt, so in teaching him to manage these losses that I perceived as trivial, I eventually realized it didn't mean that I shouldn't also try to acknowledge and respect his strong feelings until he matures and has more control over them. As a physician, this realization has reinforced that patients need empathic response from doctors not just when doctors think it deserving, but more importantly, when patients think it so. The losses that patients experience, while obviously not spilled milk, are frequent and pervasive⁸ and sometimes go unacknowledged by the physician⁹. This challenge of mindfully responding to the feelings of another requires so-called “empathic imagination” that regards and appreciates those feelings even when they are expressed in atypical or even troubling ways. As a physician, I call to mind patients who become angry at me, the ones who fight me and challenge me, who can arouse strong and negative feelings in me. Through the lens of empathy, I try to imagine that they may simply be showing me the best way they know how to express their considerable distress.

The (at times) terrifying responsibility

The look on many new parents' faces is not just overwhelming joy, but sometimes a healthy dose of fear, terror, and anxiety—“What did we get ourselves into?!” Is it fair to claim something similar for physicians? New interns learn very early the importance of the role they have assumed in their new identity as a physician. From my perspective, the look on their faces is not dissimilar to that of a new parent. Perhaps a little less joy, and a little more terror, but I suspect it is motivated by similar emotions—the weight of the responsibility they have

accepted in the face of limited experience. Interns, always first to be called to the bedside, quickly learn to take on the extraordinarily weighty mantle of caring for a vulnerable person.

Though speculating about similarities between patient care and parenthood is interesting, persistent differences remain, notably the schooling, licensing, and training to become a doctor as compared with the lack of formal training, but greater dedication and love associated with becoming a parent. But the ways in which *both* parents and physicians practice empathy, listening, and responsibility allows for rich relationships that have surely made me a better doctor while also making me a better father as well.

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