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Abstract

A regional campus dean reflects on his recent acquisition of a new clinical responsibility as medical support to an inpatient behavioral health unit. Having taught the neurological exam to students for almost 35 years, this experience caused him to pause and consider a new perspective on teaching the routine exam. The author has no conflict of interest to report, and IRB approval for Treatment of Human Subjects and Treatment of Animal Subjects is not applicable.

Riding up in the staff elevator that still smells like somebody's breakfast, I am checking my email on my phone to get the day started. The door opens on the sixth floor and I stride across the brown tiles that meet the light blue walls that lead into the inpatient psychiatry unit. I touch my badge to the wall sensor that magically opens the first door, and then step in between the locked doors.

I have learned to wait until the door behind me clicks to touch the next wall sensor to open the second door. When I first started doing this two years ago, this eight second delay tremendously irritated me. I learned to look through the glass into the geriatric side of our unit to make sure that a patient was not right up against the door, but the delay was still irritating. Then, in the middle of a mindfulness discussion with my medical students, it occurred to me what a gift it was to have those few seconds for silent reflection before I enter the chaos. After this classic re-frame, I now cherish those few seconds.

My morning schedule is tight. I need to see the two or three new patients and review lab on several others before sit down rounds with staff at 9 am. Many of the patients I see are unable to give me a coherent story or have already been sedated by the time I arrive. I have learned to do the detailed neurological exam that is required of a medical consultant in an inpatient psychiatry unit before taking much history. Then if the patient is alert enough during the exam, I can get them to tell me their story.

This presents an ideal opportunity to evaluate the patient uncontaminated by the previous "i-patient" created by someone else in the chart.[1,2] As I go through the routine exam that I've been doing for nearly 40 years, some remarkable moments occur. The patient sits on the side of the hospital bed that is bolted firmly to the floor, as is the only stool in the room, all of which are dark brown plastic. All fixtures are curved, with nothing in the room that could support a ligature of any kind.

Testing cranial nerve one with an alcohol prep brings some rich nonverbals from alcoholics and reveals the traditional anosmia shown by many patients with Alzheimer's disease. Testing visual fields by having the patient look at my nose and count my fingers in the periphery results in the patient looking directly at me. The overwhelming sadness of profound depression and the absolute wildness of psychosis are revealed in this mutual gaze and seems to make us both uncomfortable.

Extraocular muscle testing is interesting in those with dementia. Most are completely unable to follow my finger, but if I move my head like a dancing crane they continue to look me right in the eye as I go through the movements. Testing masseter function by having the patient "bite down hard" also brings a look of sadness to both of our faces when many teeth are missing.

Protrusion and movement of the tongue usually goes pretty well, except for the patients who are actively hallucinating. This seems to

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trigger some deep response that almost always results in the patient communicating with the unseen figure in the room with us. The request, “Now give me a big smile,” results in a remarkable dichotomy. Some deeply depressed patients “put on a happy face” for those few seconds that is strikingly incongruous. Others cannot make those muscles complete the task, and I have learned to say, “I know that’s hard to do now.”

Testing sensation on the face is perhaps the most telling. My standard is saying, "I'm going to touch your face lightly, and I want you to close your eyes and tell me whether it feels right or left." I am constantly surprised that almost all of the patients with dementia respond correctly. But there is a group of patients, most of whom are young women, that pause and seriously consider whether they can actually do this. Despite my best nonverbal efforts to connect with all of my patients at some level, their deep suspicion simply will not allow them to close their eyes. Some try to comply for a few seconds but are extremely uncomfortable and become agitated. When I hear their tragic stories later, I understand the looks on their faces. I have learned that having a chaperone in the room actually adds to their discomfort, although with some patients I still require this.

Muscle strength testing generally goes pretty easily. However, some patients with dementia have great difficulty deciding what to do when I ask them to press against my hands. Quite a few with schizophrenia will simply leave their arms and legs wherever they last were when I moved my hands.

Surprisingly, attempting reflexes with a small reflex hammer is generally not interpreted as threatening by even the most delusional patient. Palpation of the neck is usually not a problem, but some of the same young women pull away after a few seconds. I have learned to say very quickly, "That's fine, we don't need to do that part now."

I was trained that correct auscultation requires the chest piece to be touching the skin and not to be through clothes where unusual, adventitious sounds can arise. Surprisingly, slipping the chest piece of the stethoscope inside the hospital gown or shirt to listen in the front to the heart has never been perceived as threatening by anyone.

However, the challenge comes when I want to listen to the chest posteriorly. I am very clear saying, "Now I'm going to go around behind you and listen to your lungs." Regardless of gender or hospital unit, I next ask for permission to lift the shirt or gown to place the chest piece on the posterior chest. On this unit, this results in a bit of hesitation in patients regardless of gender. Almost universally, I later discover their stories of abuse which are usually sexual and from when they were children. Again, I have learned to agree quickly to listen through the gown if that makes the patient more comfortable. I guess that does not make me a bad doctor.

Abdominal exams usually go easily and for these patients a GU and breast exam are not indicated at this interaction. I must admit that it is always surprising how many adult patients in this unit are so ticklish that it is difficult to do a complete abdominal exam. I wonder if that is some kind of predictor of significant mental health issues. I hope not.

For the patients where rapport has been developed in this reversal of the routine pediatric exam, I seek an opening, "So tell me why you think you're here." Responses are rich and devastating at the same time. I have had a patient tell me that they are worried that they cannot die[3], and another who explained that her absolute hate of her teenage children is driven by the fact that her "rotten kids" were fathered by her father.[4] There have been times that I wished I had not sought an opening, like the time that the patient described the devils in the room and their individual plans for me. Or, the large twenty-something man who promptly pushed his face close to mine and said, “Why the f--- do you think I’m here?”

Next in my routine, I take a chance. I say, "You know, I ask all new patients, is your faith important to you?" This is not unusual for me to ask in my office, but with patients so vulnerable it always gives me pause.[3] However, despite the crazy things that we have already discussed, this

almost always brings a moment of peace mixed with genuine interest to the patient's face. Some explain that they are atheists and we discuss that a bit. Many in this Bible belt area say, “Well I just don't go to church anymore.” This gives us an opportunity to talk about the difference between faith and religion, and far too many talk about the guilt that their former religious practice has engendered. With the delusional, hyper religious patient, this can be almost comical. I have had a request for an exorcist consultation. But it is always time well spent. I do not usually offer to pray with these patients, but I do make it clear to them that our chaplain will and will see them at their request. It is remarkable how many of these patients have a Bible borrowed from us when I return to their room during their stay. We have not had a patient ask for a Torah or Qur’an yet, but we have a plan.

So, I finish my notes, go back to the double doors, and during the pause between the two I reflect on the human misery I have just shared and perhaps re-interpreted for the patient. I am also struck that almost all said, “Thank you,” when I told them we were finished. Then, back across the brown tile, past the blue walls and into the elevator. When the door opens on the main floor, it almost feels like I am stepping onto another continent. I head over to our classroom, thinking about how I will teach the next group of students how to do a Neuro exam, as I have done for almost 35 years. It is with a different perspective that I say: “First, begin with testing the cranial nerves.”

References

1. Verghese A. Culture shock - patient as icon, icon as patient. N Engl J Med. 2008;359 (26):2748-2751. doi: 10.1056/NEJMp0807461.
2. Chi J, Verghese A. Clinical education and the electronic health record: The flipped patient. JAMA. 2014;312(22): 2331-2332. doi: 10.1001/jama.2014.12820.
3. Crump WJ. But doc, what if I can’t die? KY Acad Fam Phys J. 2017;88(Winter):18.
4. Crump, WJ. Those kids are rotten. Submitted to the KY Acad Fam Phys J. 2018.