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Top Communication Strategies from an OB-GYN Practice

Ms. Rosario:
Welcome to *Advance's in Women's Health* on ReachMD. I'm Ana Maria Rosario, and I recently sat down with Dr. Patricia Boatwright, who is the Women's Health Medical Director at Louis A. Weiss Memorial Hospital in Chicago. Dr. Boatwright is here to share with us her perspective on communication with patients and colleagues. Dr. Boatwright, welcome.

Ms. Rosario:
Are there common questions or things that internal medicine, primary care, or even some young practitioners should be asking their patients routine questions that are, probably are, that would seem common to you, right?

Dr. Boatwright:
Medicine is changing, we're getting closer and closer to socialized medicine. We're considered primary cares as OB/GYNs, especially those of us that are hospital-based. They're requiring that we see a certain amount of people in a certain amount of time. But we are so time-influenced now with these exams. So I limit my practice to the specialty of OB/GYN. And therefore, I'm not gonna be critical of them for taking time to ask more about hypertensive disease, the internist, than what I would ask about. But that's why I encourage those patients that are able to see the specialists, the gynecologists, as opposed to combining us and seeing, having your primary care do both your general medicine and your gynecological care. Especially in the age group of around 28 to 65 because that's when we pick up a lot of our pathology.

Ms. Rosario:
Some patients may have a mindset, when it comes to illness, that "if it doesn't bother you, don't bother it." What do you make of this? How would you debunk this mindset?

Dr. Boatwright:
To release the fear. If you trust your intuition, your body's extremely bright. All of us know when something's not quite right. And it doesn't have to be a lot. So never disregard your intuition. Never disregard abnormal bleeding. Don't try to catch up with my knowledge-base with the internet. Rely on your trust rely on your specialist when you go for that exam, for us to educate you, to get it from the horse's mouth. Put it on us. That's what we do for a living.

Ms. Rosario:
Yeah. And that brings me to my next topic I wanted to ask you about, which is mentoring colleagues and physicians to deal with that "I want" versus the "I need". Can you shed some light on your perspective on this?

Dr. Boatwright:
Participate in your healthcare, be informed, make an informed decision with your primary care or your specialist, and that's great. And I tell patients all the time, "I'm an educator. Not only of residents, not only of other doctors, but I'm an educator of my patient population, too. I want you to understand what's going on and why I came up with this plan of action on how to make the diagnosis and give you the treatment options." Patients will come in knowing, for instance, that they have a fibroid tumor, and they could be 60-years-old, they will say to me, "Boatwright, I have a fibroid tumor," and I say, "Don't tell me anything else, let me do my workup. I'm gonna ask you a few questions, I'll do my exam, and then we'll sit down and talk." Now maybe they've had an ultrasound and really I'm a second opinion. And then the 60-year-old will say, "Boatwright, I want a myomectomy," that's the removal of the fibroid and keeping the uterus. And I will say, "I don't want you to say 'I want' until I understand why you should maybe not want that." And I will tell you that she will show me articles

from the computer, from the internet, on why she wants her uterus, not knowing that number one, the uterus only has one purpose in life and that's to carry your pregnancy state, that you do a myomectomy, and you don't achieve a pregnancy state because you're maybe post-menopausal, the chances of your uterus having problems with fibroids 30 percent recurrence in 3 to 5 years. And a 60-year-old who's had a rapid growth and abnormal bleeding with her fibroids is at risk for something called a "sarcoma" which is a degeneration. And lastly, a myomectomy is more difficult, as far as procedurally than a hysterectomy. I'm not a plastic surgeon, I'm a patho-physiologist that happens to be a surgical person. So I remove that stuff.

Plastics, you go in, you want your hips slimmed down, you want your nose to look different, you can say, "I want." For me, I am a patho-physiologist that will say, "This is what I'm presented with, this is your best option, and many times, I'm able to give you choices, and that's when your 'I want' will come into play." Now this is difficult because sometimes the patient is and I put it in quotes, "So informed, she's not listening." And that's the patient you send for a second opinion. Or that's the patient you will say to, "I am very understanding of your wishes and the 'I want' but I will not be able to render the care because I only do A+ medicine, or maybe an A, or occasionally an A-, but I can't do a C or a D or even a B. So, in that case, we'll go for a second opinion and you're always welcome to come back if you indeed, find that my train of thought is what you really wanted and now that you're better informed." Now that's after I've gone through a lecture 'cause I love teaching and I love teaching my patients too on why I have elected to do A and B as opposed to what she wanted, which was C or D.

Ms. Rosario:
Do you feel that some of your colleagues and other clinicians feel empowered because there's this power of the internet and power of information out there? Do you think that other clinicians feel as comfortable having that conversation or being able to guide that conversation?

Dr. Boatwright:
No. They don't. Some of the younger kids, and I always tell when the younger kids present to me, "Well, Boatwright, you can say that. I can't say that." You have to learn to say that because that's important. If you don't feel comfortable in challenging that patient with the "I want," then maybe you shouldn't be doing what I do, because you do her disservice.

Now let me tell you this, this is important, I have to present this case. I'm doing a hysterectomy, occasionally at Rush, I have my favorite chair, I would come up between cases to the obstetrical suite and I would always look at the board and look at the tracing. I've always educated the residents and many of the attendings there. And I saw a case and I said, "Mmm. That's not a good baby. Where's the doctor?" And it was someone I trained. "Tell her I'm not doing anything, I'm between cases. That lady needs a C-section, that baby doesn't look good on that monitor." And the doctor comes to me, and she says, "Boatwright, she is a neonatal nurse, and she wants to have a vaginal delivery." I said, "But the baby doesn't look good, and she's been stuck at this centimeters for so many hours." "But she wants another couple hours." I said, "But the baby's in jeopardy and you have two patients, you have the mother with the "I want" with the jeopardy," and there's not a gray zone for me. "Boatwright, I can't tell her like you can tell her." And I was very critical. The outcome for that was negative. I will tell you that. For both the patient and the baby. But it was a learning experience for that doctor, and I sat down, 'cause she was distraught, I said, "Learn this lesson, you have to be able to tell the patient directly and not give them a option because that was not an option with the "I want." Patients don't know that they don't want, and they can't catch up with your knowledge base or my knowledge base to know that.

And furthermore, you never put on an obstetrical patient, she's depending on you to tell her how to get a beautiful new spirit into this world. For me, I did the best I could, based on my knowledge base. And that's all that I ever ask of myself. For the mom, she didn't know she should not have made that decision. And now she has potentially a compromised baby that she will blame on herself as opposed to putting the blame on me, which I can take 'cause I did the best I could, based on my knowledge base and my clinical intuition.

Ms. Rosario:
Are there any final thoughts or things that you think in regarding that "I want, I need" patient or for what we just spoke about?

Dr. Boatwright:
Just to continue, usually you can get past the "I want" if you educate. In order for you to educate, you have to know, so make sure that you are up on your game, as far as knowing normal anatomy, normal physiology, and therefore the patho-physiology. That way you can communicate to the patient better in that she can understand why she may not want what she thinks she wants. It's for us to educate her on that specific chief complaint so she can feel comfortable with the management plan.

Ms. Rosario:
I like that. That's a good game plan to keep in mind and when you're having those difficult conversations or a difficult patient coming in. Well, Dr. Boatwright, this has certainly been an enlightening conversation on how practitioners can effectively communicate with their patients and colleagues.

You've been listening to *Advances in Women's Health*. To revisit any of this discussion, and to hear more of my conversations with Dr. Boatwright, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.