Sawbones 508: The Doctor Patient

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Clint: Sawbones is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and try not to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Well, hello everybody, and welcome to Sawbones, a marital tour of misguided medicine. I'm your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: Hi, Sydnee. Welcome.

Sydnee: It looked like you were turning my mic off right as I started talking.

Justin: No, that would be a terrible thing to do to you, and I would never.

Sydnee: You couldn't… You also couldn't do this without me.

Justin: Not too bright to podcasting.

Sydnee: You couldn't do it without me.

Justin: That would be wild. Certainly for this episode, I will say.

Sydnee: Yes. Well—

Justin: Every episode.

Sydnee: All—all episodes.

Justin: But I would say double, triple, quadruple this episode.

Sydnee: I could—I think history has proven, though, I can replace you.

Justin: I'm replaceable. You are not. This is known.

Sydnee: With Charlie.

Justin: This is not new information. This is known.

Sydnee: No.

Justin: Well established.

Sydnee: Honey, you are an essential part of what we do here, and we want you to know how valued you are. Here's some pizza.

Justin: Oh! Heck yeah! Wait, why would you say that and not have—where is it?

Sydnee: I was just joking.

Justin: Oh. That's a pretty mean joke! As far as jokes go.

Sydnee: The young people get the joke.

Justin: Okay.

Sydnee: Yeah. It's about your manager trying to give you pizza.

Justin: Yeah. You got a lot of problems with that at Harmony House? Your manager trying to give you pizza at Harmony House?

Sydnee: [laughs] Well—well, listen.

Justin: Big problem down there?

Sydnee: It's an unconventional structure where you don't get paid for work, so.

Justin: Well, you don't get paid for work. [laughs]

Sydnee: Well, I don't get paid to work. Everybody who works there does get paid for work.

Justin: [laughs] Sydnee was using the royal you. Uh, Syd, what is this week's episode all about?

Sydnee: Well, Justin, this one's a little different than our usual episode, because I get a lot of questions—I check the email, and I tell you about them sometimes. I get a lot of questions about navigating healthcare experiences and about kind of the way the healthcare system works, because we don't make it easy to understand in this country. And it also doesn't work well.

And so, even if we can tell you how it's supposed to work, that typically doesn't reflect the reality. So, I think that it might be useful to share an interaction that I had with a healthcare system, sort of a process that I went through, what that was like. Especially being a doctor who was the patient. I think it's a really important experience to have, so that you can understand what the people that you're taking care of go through.

So if that would—if that would be something you're agreeable to, I thought that might be useful for our listeners.

Justin: Absolutely. I would love to hear more.

Sydnee: And I want to preface with, at the end of this—I go through some testing in this story. At the end of it, everything is fine. I am fine, and I am healthy, and I am—

Justin: There's no suspense in this story.

Sydnee: There's no suspense. Everything turns out fine. I think that would be a really terrible kind of triggering episode to say, like, "I'm not gonna tell you how the testing that I went through turned out until the end." That would be a terrible thing to do.

Justin: If we were smart it would be a two-parter with a cliffhanger..

Sydnee: No. I would not put you all through that. Everything turned out fine. I was very lucky. Everything was fine. But... when you don't know, it doesn't really matter if you're a doctor or a patient, or a doctor who has become the patient. When you're going through the process, it's very scary, and it can be hard to navigate even when you have kind of an in, so to speak.

So, last—this started last... January. Correct?

Justin: Yeah. Yeah, yeah, yeah.

Sydnee: Was went in for the original—

Justin: That's right.

Sydnee: Yeah.

Justin: Yeah.

Sydnee: So late last January—I believe that's right—I went for my first ever screening mammogram.

Justin: Now, you say screening mammogram. What's the difference? So, a screening testing means that we don't necessarily believe there's anything wrong, that there's a diagnosis, that there's some of pathology. It is just a routine exam that checks based on whatever your risk factors are for something. Usually we think of screening tests for cancer.

So, certain ages, depending on other risk factors like behaviors you may have engaged in in your life, sometimes gender or racial factors can play a role in this screening—

Justin: Why were you getting the screening? Why now?

Sydnee: I was screening because I had turned 40 last year. And in your 40th year it's recommended that you get your first screening mammogram. I had not felt any lumps or masses. There was nothing that made me think I had an issue. But it was just time to get a routine, standard mammogram to—really what you hope to do is set a baseline. This is what my exam looks like typically. And then future exams, what you can look for are changes.

That's really more helpful in medicine a lot of the time is to have the past x-ray, mammogram, CAT scan, ultrasound, whatever, imaging study to compare to this current one. When you have that first one done in a vacuum it's really hard to know, right?

Justin: Right.

Sydnee: Have these things we're seeing been there for... ten years, ten months, ten days, ten hours? We don't know. We just know they're there know. And a lot of things that we're looking for, specifically cancer or things that could become cancer, it's their change over time that makes us more or less suspicious and leads us to more testing. So—

Justin: So you're kind of getting a baseline.

Sydnee: Hmm?

Justin: You're kind of getting a baseline, from which you can judge how things have changed.

Sydnee: Yeah. That's exactly what I was there to do. I obviously—so, I had turned 40 in March of last year, and I got—

Justin: [snorts]

Sydnee: Yeah, I got it in January the following year. So right—that was actually very intentional. I wanted to get it before I turned 41 so I could say I did when I was supposed to. I did it while I was 40.

Justin: [laughs]

Sydnee: I did technically do it while I was 40. So I went and got the exam done. And the thing is, they tell you multiple times—and I would say this is probably true most places where they do mammography—where they do mammograms—they tell you so many times that it is not uncommon if it is your first mammogram to find something that they'd like to do some followup imaging on.

Justin: Right.

Sydnee: They tell you that at every step of the way. I went in to—here locally we have The Breast Center where they just do mammograms, ultrasounds, biopsies, whatever you need. They do it all there, so all breast stuff happens in this building. It's right across the street from the hospital where I work. But it's a separate building.

At reception, the nurse who took me back to tell me to get changed, the tech who did my exam, and then the person who told me to wait in the waiting room for my results afterwards, they all said the same thing. "Don't be surprised if we tell you that you need some sort of imaging, usually an ultrasound, after your get your mammograms. That is very typically."

Justin: Everybody in the chain was giving you the same information. It was the same warning.

Sydnee: Yes. Now, you would think with that knowledge...

Justin: [laughs]

Sydnee: ... that afterwards when that is exactly what happened, I would not be shocked. And let me say, can I—

Justin: You're getting ahead. You're getting ahead of yourself a little bit.

Sydnee: I was gonna say—

Justin: You're getting out of sequence a bit.

Sydnee: I—well, I know. Well, I realize, I should probably walk you through. If you've never had a mammogram or performed one—perhaps you work a mammography center—then let me tell you what it's like.

Justin: Okay.

Sydnee: And I feel like this is also—there's so many, like, sitcoms that have joked about this before. [laughs quietly] The mammogram process. I don't wanna be one more person doing, like, "Here's my tight five on getting a mammogram." [laughs]

Justin: [laughs]

Sydnee: A lot of it's true. So you go back into the waiting area. They put you in. I was in, like, a little cubicle that had, like, a bench and a mirror, and then a hook on the wall.

Justin: [simultaneously] Nice. All to yourself?

Sydnee: Yeah. It was like—they had a bunch of little—they're changing cubicles. So I had a little teeny cubicle where they had, um, a gown. Which, the gown that you put on—so you take everything off above the waist. And the little gown you put on—it's usually made of the same sort of material as a hospital gown, so it looks—if you can—I mean, in all hospital gown, the design is a little bit different. But they're usually, like—like a, like, white or cream color, and then they've got some sort of repeating pattern on them, I feel like. Like, that's the classic hospital gown look.

This is like a shawl. You drape it over your shoulders. And it just, like, sits—

Justin: Like James Brown would put on after a concert or something? Kind of—

Sydnee: Yeah. And then it's got, like, one little snap right in the front.

Justin: Flirty! [laughs]

Sydnee: Now, I will say, across the back it's shorter than in the front, where it hangs down. Like, the two panels of fabric hang very down in the front, so.

Justin: I mean, those are the stars, right? You wanna—that's who you need to cover.

Sydnee: Well, I mean, they hang, like—it was almost down to my knees. So, like... [laughs quietly]

Justin: Well, okay, Sydnee!

Sydnee: I'm just saying. Like, it's a very strange garment, but it does the job, so I understand it. It makes perfect sense. It did the job quite well. It kept me covered. It would—

Justin: Nobody wants to be the person who's like, "Excuse me. My bosoms are too big for the apron." They've just saved someone the indignity of saying, "My gimondo bazoo—" [wheezes]

Sydnee: Yes, Justin. And that's exactly the kind of language they encourage using when you're getting cancer screenings.

Justin: I'm just saying, Sydnee! I'm just saying that they're multipurpose, and you should celebrate that.

Sydnee: I will say that the size of this gown would cover I think the entire range of breast sizes, and so that's good. That's a good thing.

So you sit in your little cubicle. I could hear music blasting through the wall, which was kind of strange.

Justin: [simultaneously] Heck yeah. Why?

Sydnee: It was like some sort of, like, 80's rock station. I think I was sitting right next to the room where the radiologist was. 'Cause they have a radiologist there, housed at the breast center. I think I was right next to where the ra—

Justin: So this guy's just on the other side of the wall looking at cancer screenings like "[singing] Everybody's working for the weekend!" [laughs]

Sydnee: Blasting ‘80s music.

Justin: Crankin' it?

Sydnee: He was.

Justin: Oh, man. That's good.

Sydnee: Or she was. I don't know.

Justin: Or they were.

Sydnee: It was a he, it was a he. Because I know who read my report. Anyway—and that's very typical, by the way. I have been—so, I don't know, and you may be a radiologist who doesn't do it this way, but I am not a radiologist. In my career I have many times walked down to the radiology suite at the hospital to talk what radiologist about a study that's really—by the way, if you're in training, if you're a medical student, if you're a resident, that's a wonderful thing to do. And most radiologists—[laughs] most of them—will welcome you doing this.

Come and say, "Hey. Can you talk with me about this study that you read? And I can give you some clinical information. And then we can talk about it together. Like, do you really think it could be this or this?"

That's a wonderful thing to do, and you learn a ton. So I've done this many times. And they're often sitting in dark rooms looking at screens, blasting some kind of music. It's not always 80's rock, but some kind of music.

So I sat there in my little cubicle until the nurse came back to get me. She took me into the mammogram room. The mammogram machine—I mean, you can look up a pic. I'm not gonna describe—you can look up what a mammogram machine looks like. The important thing is, you are going to

get so up close and personal with this machine, and with the professional whose task it is to get good images.

Justin: Way up in your business.

Sydnee: And they tell you this, but I don't think anyone ever tells you how up close and personal until you're in the moment.

So, they need to—in order to get a good picture of your breasts, what they want to do is compress the breast tissue between the two panels of the machine, okay? Kind of flatten it between. And that—and that kind of makes, like, common sense why that would give you a better picture of the breast as a whole than trying to—I mean, you can imagine if you just pressed it against your chest, then you're taking images of everything behind the breast tissue. That's not useful. That's gonna create problems. You really need to... something above and below that's going to sort of flatten the breast.

Justin: I don't wanna—I don't know how to—I mean, I'm not asking for PSI, I guess. But like, what kind of pressure are we talking about with this machine? Is it a—

Sydnee: It is uncomfortable. It is not—a lot of people told me it was painful, and certainly I will say I think it would probably depend on how sensitive your breast tissue typically is, maybe where you are, if you are someone who menstruates, where you are in cycle. I mean, there's lots of factors as to how sensitive your breasts might be. I would not use the word "painful." It is definitely uncomfortable. It is tight enough—and I think it kind of triggers that sort of panic response. I had a moment of that. Where as it—as I was completely compressed in the machine, you realize you could not withdraw yourself.

Justin: Oh, man. I hate that feeling.

Sydnee: Yeah. It was tight enough that to just try to pull away from the machine would cause injury.

Justin: Gives me chills just thinking about it. I hate being penned in by stuff.

Sydnee: So I think that that's part of when people describe it as, like, a very uncomfortable or even painful exam. I think part of it is that sort of innate panic response, fight or flight. Like, "I'm stuck to this machine!"

Justin: Yeah.

Sydnee: "I can't get myself out. What if the power goes out? Oh!"

Justin: Once—

Sydnee: Which I'm certain there's a way to open it even if the power's out. I'm certain that that can happen.

Justin: Once you're physically in the room, what kind of pace are we moving at here? Is this a quick thing? Are they trying to limit the amount of time that you're in this kind of vulnerable place? Or is that kind of just, like... [crosstalk].

Sydnee: Uh, they limit the amount of time that you're exposed, for sure. I mean, I had my gown on all the way up until I was putting myself into the machine, so to speak.

Justin: Wait, you put yourself in the machine? They don't have a professional do the stuff?

Sydnee: No. So, what happens is you—you lay your breast on the bottom panel, basically. You kind of push yourself into position. And you almost have to, like, as you do each side, you kind of have to hug the machine. You have to, like, press yourself against it to make sure your breast is completely in it.

Justin: Okay. Now, at this point—

Sydnee: And then you have to extend your arm out and kind of pull yourself against—like, I was embracing the mammogram machine.

Justin: At this point, I'm into a balance issue, I feel like. At this point, I'm severely worried about losing my footing.

Sydnee: It's a—you have to—and I will say, the tech that I worked with was amazing, because she talked me through every step. So, it was not quick in the sense that—she wanted to make sure that I knew what I was doing, that I was comfortable, that I was standing in a position I could hold. And that she got the images that we needed, I mean, that's the other thing. They don't wanna bring you back to do it again because they didn't get the appropriate images. They want to get it right the first time.

And so they are very—I mean, the person who assisted me was very meticulous. And once I was in position and she showed me where to put my arm and she said "Yes, you're gonna squeeze the machine like—" you know, I mean, she told me how close I was gonna get.

She then positioned my breast in the machine. Like, you will—you know, that is part of going through this process is the person who's responsible for getting the images will make sure that your breast is positioned appropriately, and continue to readjust you and check the machine until they are certain that they have, you know, that they're going to get the right images that you need.

Justin: Yeah, okay.

Sydnee: And you do everything you do on one side, then you turn around and repeat on the other side.

Justin: Is there, um, any kind of warming gels or anything like that involved?

Sydnee: Not for the mammogram.

Justin: There's no—okay.

Sydnee: Not for that part of this.

Justin: I know there's some stuff they put on, like, your belly when you're doing that kind of—like, ultrasound kind of thing. So I didn't know if there was a—

Sydnee: We will get to that.

Justin: Okay.

Sydnee: But this was just the mammogram. At this point, all I was getting was the same uncomfortable exam that I had heard about from not just doctors and colleagues, but from standup comedians for a long time.

Justin: Actually, I should have asked at the beginning, but super quick, 30 seconds, what is a mammogram?

Sydnee: They're just taking pictures of the breast tissue.

Justin: Okay.

Sydnee: It's just a—it's a special form of imaging that is specifically designed—like, the machine is designed, the way the breast tissue is compressed. And they are looking at the density of your breast tissue to try to figure out, are there any masses in there? Are there any lumps? Are there cysts? Are there something that could be precancerous? Are there cancerous lesions? What does the tissue look like in the breast? Just like any other imaging modality is sort of calibrated for what it's taking a picture of. Is it looking at tissue, or fluid, or empty space, or bone, or—you know. This is a machine that is specifically designed to take the best pictures possible of breast tissue.

Justin: Okay.

Sydnee: Which is, like, fatty and lymphatic tissue for the most part. It's like a gland, and fat. Anyway. So you go through this process at least at my center. And probably this is different depending on where you go. I was told by the tech this last time I went—I thought this was interesting. You don't have to stay to hear your results right away, but you can. And they're usually pretty fast. And for me, oh, I wanna know. I don't wanna think

about—I don't wanna stay in the worry zone for one second longer. But some people—she told me this. I thought this was interesting. Some people are out of there immediately and are like, "Just call me. My doctor will call me. I don't care. Out." And I think it's just how you're wired.

Justin: Yeah. It's interesting.

Sydnee: But anyway, so after the exam was performed and she knew she had gotten the images she needed, they let me go back to my cubicle. I got changed, and they told me to wait out in the waiting room. I waited—I would say that first time I didn't wait very long. It was probably, like, maybe ten minutes. Maybe 15. Not that long. They have a TV that's muted, but it was on HGTV, so that's great.

Justin: Hey, bonus, yeah.

Sydnee: And then at the end of 10, 15 minutes, the nurse who did the exam came back out with my little folder, walked over to me, sat down next to me and said, "So, just like we warned you... "

Justin: [laughs]

Sydnee: "Sometimes we see something and we're not sure what it is, and we're gonna have to get some follow up images, so we're gonna need to schedule you for an ultrasound, because the radiologist saw a shadow."

And this is all I'm told. And nobody, by the way, at this point knew that I was a physician. So I think that—

Justin: Was that a conscious choice? How did you—

Sydnee: That is a really interesting question. And I have more to say about it than can fit in just a few seconds, so I'm gonna make you go to the billing department with me before I answer it.

Justin: Okay. You're always doing this in our regular conversations, but to hear you do it to our listeners too is rough. Sydnee's always pay walling conversations we have.

Sydnee: [laughs]

Justin: Um, I guess, yeah, if you insist. Let's go to the billing department.

Sydnee: Let's go.

[theme music plays]

[ad break]

Justin: So, Syd, you—as you were leaving for your exam, I remember you took off your floor length lab coat and the mirror you wear around your head—

Sydnee: Uh-huh. Uh-huh.

Justin: —[through laughter] and your stethoscope, and your ID tag and everything. You said, "We're going incognito."

Sydnee: Can I say, I had to wear my white coat for this video thing I was doing recently and it was so hard to find my white coat, and then putting it on felt so weird. It was still, like, creased from where it had been folded. Anyway.

No. I don't tell people typically. I mean, now, my—like, my OBGYN knows I'm a doctor 'cause we work at the same place. We're colleagues. My family doctor knows I'm a doctor 'cause we work in the same department. We went to med school at the same time. So—

Justin: Right. You don't put on a mustache and say, "Hello, I am Doc—uh, not Doctor. Who is Doctor?"

Sydnee: "Who is Doctor?" Uh, no. So, in those interactions they know I'm a doctor. In this interaction, and most of the time when I'm outside of my system, I don't tell people that I'm a physician because...

Justin: Sounds braggy. [laughs quietly]

Sydnee: [laughs quietly] Why does that sound braggy? To not tell people I'm a doctor?

Justin: No, I mean it would sound braggy to say.

Sydnee: Oh, oh.

Justin: Like, you know, "I'm a doctor too."

Sydnee: No. I... I have invoked in one time, when one of our children had to interact with a doctor, had to go to a doctor's appointment. And this physician was going all the way around the bend to explain something to me medically, and I knew that it was gonna take a while. And so I was gonna save her some time and headaches and diagrams she was about to draw if I said "By the way, I'm a family doctor."

And she was greatly relieved, because I knew I was about to get a very—and she was doing a great job. But I also knew I didn't need the complex explanation. And that seemed rude to make her.

Anyway. For me, I don't want to engage my doctor brain about myself. I think part of it is a very logical thing. You shouldn't doctor yourself. You should let other people help make those decisions. Because it's hard to think logically about your own healthcare, um, in the risk-benefit kind of... I think we tend to either dismiss it as "There's no way I could possibly be sick. I can't be a patient, I'm a doctor." I've said this before on the show. It's hard to think of yourself as both.

I think the other way you could go, which is what I was doing, was catastrophizing. I know everything a density or a shadow or whatever—whatever they wanna call it, I know everything that can be. And I have seen—not only do I know all the technical words in the textbook what it could be, I could conjure up the image of a patient that I have cared for with the entire range of those things in my head.

Justin: Sure. You know too much.

Sydnee: I know too much. And I have seen the no big deals, and I have seen the very big deals. And I know how all those stories ended. And that is a lot to keep in your head when it's your body.

So I don't want to be a doctor, so I kind of turn that off as much as I can. And I—it's easier if they talk to me like I'm a—like I have no—I don't necessarily have any medical expertise. It's just easier. Just talk to me like you—assume I don't know anything. And if you say that but they know you're a physician, they still don't. They still don't.

Um, and if you—if they don't know you're a physician, they just talk to you like, you know, you're a patient. And that's kind of all I wanted to be in that situation. In that case, just saying "We saw something. We need to get an ultrasound."

Is vague enough, which is kind of what we're trained to do. Don't use—man. I can't tell you how many times I was told this. "Don't use the c-word unless you really think it could be the c-word."

Justin: Wow. I have heard that much differently.

Sydnee: [laughs]

Justin: Um, okay. I... I'm not sure you're right about that Sydnee. I was told "Don't use the c-word pretty much across the board" for me. Is it different...

Sydnee: It's different—it's a different c-word.

Justin: Okay.

Sydnee: I'm talking about cancer. But even in medical school, even in my training they would say, "The c-word." Let's be grownups. Let's just say cancer.

But the point is, we are trained not to introduce that word into the conversation until we know it's either a distinct possibility or a certainty. For what they saw in my mammogram, it was highly unlikely that it was cancer.

Is that on the list of things it could be? Yeah. But it was highly unlikely. And so in that situation you're not gonna tell the patient "It could be cancer!"

Because you're almost certain it isn't, and you know that's all they're gonna hear. Once you say the word cancer, your patient doesn't hear anything else. And so we're trained not to introduce it into a conversation until we know we have to.

So they told me that they were gonna have to schedule me—

Justin: Isn't that interesting, though? Because it is already in the conversation.

Sydnee: It is.

Justin: You know what I mean? It's so weird. We're—it's, like, such a quirk, I think, of the way we're put together. Like, it's in the conversation. Like, this is obviously what we're [crosstalk].

Sydnee: It's what we're all worried about most of the time. And, you know, it's interesting. I wonder if that's a—there's so many flaws, as we've talked about on this show many times, in our medical training and in the way that we teach doctors to be doctors. There's so many things we could do better. I wonder if this is another area.

We're already thinking, "Is it cancer?" And oftentimes I will have patients say, "Could it be cancer?" So we'll just have to jump to that conversation. Why don't we just address it up front? "I know what you're worried about. The likelihood it's that is extremely low. I'm not telling you zero." You can't tell people zero until you know it's zero. But why don't we just address it?

Justin: Well, that's tough too, because what the patient wants you to say is "There's absolutely nothing wrong." Like, what they want is you to say, "Concretely, it is not cancer and it couldn't be cancer." But if you leave any daylight, the person on the other end hears, "It's definitely cancer." [wheezes] You know? Like, or at least my brain would.

Sydnee: And that was—I mean, I knew. I knew. And then once I got my report I knew that one of the things this could be—that it was highly unlikely... but possible.

Justin: But even that is like, part of—it's all part of a broader conversation, right? It's a very different conversation, but it still would just be the beginning of a conversation.

Sydnee: So I, uh—the difficulty I came up against at that point is my family doctor, who had ordered my screening mammogram for me, had actually left our practice between when she ordered it and when I actually had it performed. 'Cause there was, like, a month and a half in between, something like that. Which is not atypical.

Here's a weird thing. And this might be different in your area, but let me tell you a truth about here.

Justin: Honey, I live in your house.

Sydnee: I'm talking to our listeners. Uh, here, getting screening cancer tests is way harder. Like, getting them scheduled in a timely fashion tends to be way harder at the end of the calendar year than at the beginning, because it has to do with deductibles, and a lot more people are trying to get colonoscopies and mammograms and stuff scheduled when we get to, like, the back half of the year than at the front half.

So that waiting period I had back in January was probably not that bad in the big picture, whereas you might wait much longer as the year goes on. Interesting little piece of information.

So I—they sent—what they told me at the desk, after the nurse gave me my results, she walked me over and handed me over to the front desk person and handed them my chart. And they said, "Okay. We're gonna send a request to your doctor to order an ultrasound of your breast so that we can see what this density in your left breast is."

Okay. Well, the problem with that is my doctor had left the practice. So they were going to send something, and because it's in my office I knew how this

was gonna go. A paper with that doctor's name was gonna get faxed to my office. They were gonna look at it and say, "Well, she's not here anymore."

And if I was really lucky...

Justin: They might forward it to her.

Sydnee: No, they wouldn't forward it to her, 'cause she's in a totally different practice.

Justin: [crosstalk] Let her know it's there or something?

Sydnee: If I was really lucky they would show it to another doctor there and say, "Does anyone know who sees this patient now? Another doctor needs to take over this patient."

But... probably it would get shredded, and nobody would ever order my ultrasound. So I was freaking out.

I knew who was gonna take me over as our family doctor, but I had not actually seen her yet, because I didn't really need to yet. And so I was basically now in a situation where I had to find a doctor to order this ultrasound for me... and also I'm freaking out.

Justin: Right, yeah.

Sydnee: So I was lucky. I, uh—my OBGYN is somebody I can get a hold of. And this family doctor that I knew I was moving to was somebody I had gone to med school with, and so I could reach out to and say, "I know it is wildly inappropriate to text you about this, but I am freaking out." Uh, which—

Justin: Do you realize—I mean, like, do you hear—I mean, when you line it up all together like this, how... how do we expect anybody to do this?

Sydnee: It took me several hours of texting people. And everybody was working, so nobody was neglecting me. They were just working! They're

working, they're doing their jobs. They can't cater to my needs immediately, right? They shouldn't have to. But I'm losing it.

So all I—so I want somebody to cater to my needs immediately, which is a normal thing that we all experience in these kinds of situations. I was lucky enough to have access that most patients don't, because I got cell phone numbers. I can text. I've got secret Doc Halo doctor text. I can send secret text messages to other doctors in my system, saying, "Could you please order this ultrasound? Could you—" you know. So I was able to get an order relatively quickly.

And not only that, because it was for another doctor, it was followed by a phone call saying, "Hey, do you think you can get her in quickly?"

Justin: Right. Greasing the wheel a bit.

Sydnee: Yeah. These were not things that I requested. These were things that just happened for me because I am a physician in the system. Which isn't fair or right, or I'm not saying—I'm not stand—now, at the moment, did I refuse it? Did I say, "Oh, by the way, don't try to get me in faster." No, 'cause I was a scared patient.

But to your point, that process that I went through that took me a day to troubleshoot, and I was on the ultrasound schedule for the next day, would probably take a few weeks for someone who didn't have special access to the system.

Now, if your doctor didn't move practices, and they just sent the order to 'em, it would probably just take another week for them to respond, get the order in, get you scheduled.

Justin: But how many stories do you hear about people falling into these cracks? I mean...

Sydnee: Mm-hmm. And, you know, again, when you want to talk about privilege in the healthcare system—so, I'm somebody who is uniquely tied in to the system because of my—not just what I do, but because I work at the facility where I was having it done, so I have direct access to this facility. If

you remove me from the facility, it gets harder. If you remove my profession, it gets harder.

Now, what about all the other things that I have privileges in? I have insurance. I have transportation. I have a husband with a flexible work schedule where if I need you to get the kids for me or whatever, so that I can go to an appointment right away, I've got that.

Justin: Flexible work schedule, can I just say, such a nice way of saying "unimportant job." I really appreciate that. Thank you so much.

Sydnee: [laughs quietly] I—I have a flexible work schedule. I can leave my work and go get a mammogram right away if I need to.

Justin: Sure, right. Yeah, yeah, yeah. Yeah.

Sydnee: Right? Like, we both do.

Justin: We're very lucky in that sense.

Sydnee: Like, the amount of privilege that we have to facilitate getting that quickly, compared to somebody who doesn't and how much harder that process would be and how much easier it would be for exactly that, for them to fall through the cracks.

Justin: Y'all, I was at the hospital this week for two hours and 45 minutes to get an appointment to come back for a surgery, and that's literally all I did there. [wheezes] It's wild! I got forgotten for 45 minutes. I had to call Syd and say, "Hey! What should I do?" She said, "Oh, they probably forgot you." [wheeze-laughs] Like...

Sydnee: Which they had.

Justin: They had. They had forgotten the J-man.

Sydnee: All of that—all of that to say, it really—we make it so impenetrable., this healthcare system. And if it weren't for shortcuts, I certainly wouldn't have gotten an ultrasound scheduled for the next day. And for some people,

if it weren't for shortcuts or special, you know, access, they may indeed fall through the cracks.

Say, "Well, I guess my doctor will call me with this other appointment." But your doctor never gets the message. And six months go by. You know? I mean, or more. And then there's the whole health literacy. I knew what was at stake because of my training. If somebody just says, "We saw something. It's probably nothing. We'll probably need to get an ultrasound. Don't worry, don't worry."

You might hear, "Oh, well, it's probably nothing." And you don't worry. But what if it is? So, anyway, I went the next day. You went with me for this part of the experience. I—same place, registered again. Went back, same cubicle. The only thing that was distinct about this experience is that the radiologist was blasting Don't Fear the Reaper...

Justin: Unbelievable.

Sydnee: ... while I was getting dressed.

Justin: Unbelievable.

Sydnee: Which is, like, not great for a cancer screening center, guys.

Justin: It shouldn't even be on the playlist. [wheezes]

Sydnee: Can I say—can I say that everything else about my experience there was very nice. Everyone was very nice, and thoughtful, and patient, and kind, and warm, and—

Justin: It's just the Blue Oyster Cult, y'all. We gotta—

Sydnee: Yeah, it was just the Don't Fear the Reaper. But I went and I had an ultrasound of my left breast. Uh, that experience is where they use the warm gel, and they did. They had the little thing that they put the bottle of jelly in that keeps it warm, so when they squirt it on your boob it's warm. That's really nice. I know. So you're not cold.

Um, they keep your other breast covered. Like, you kind of lay on your side and you wear the same little thing, and you just uncover the one breast that they're ultrasounding, so it's all very—you know. And they've got a curtained-off room. The lights are kind of dimmed 'cause they're using an ultrasound machine, so it's better if it's not too bright. It's all a very peaceful experience.

Um, she did the ultrasound of my left breast. I did ask her to tell me what she was seeing. I don't know if at that point she suspected that I had medical training, because why else would I ask for specifics?

She told me as she was doing the exam—and an ultrasound is you take the little wand and just kind of rub it over the area that you're trying to, like, bounce sound waves off of and get an idea of what kind of tissue is in there, basically, and the density of the tissue tells you a lot about what it might be.

So as she was doing it, she said—and this is unofficial. The techs are not allowed to give you the official report. The radiologist has to. But she said "It looks to me like a lymph node." And then she told me what a lymph node was, which... I know what a lymph node is. But I let—I will always—I'll take it. You tell me. That's fine.

And so she was explaining to me that it was probably just my body reacting to some sort of infection, or allergen, or something, and my lymph nodes enlarge and make antibodies, and it's 'cause my breast's a gland, and blah, blah, blah.

And it's probably nothing. But she was gonna get the radiologist to look at it. She did find another one. She was like, "Oh, I actually see there's another area, too," which was a very, like... "I'm gonna vomit" kind of moment.

Justin: Oof.

Sydnee: I went back out to the waiting room with you. And do you remember what happened?

Justin: No.

Sydnee: You don't remember that? [laughs quietly] How do you not—this whole day is, like, burned on my brain forever.

Justin: My brain works the opposite with days like this, where it's this level of panic. I have almost no memories. Like, it's nothing.

Sydnee: I remember every second of it. I was asked to come back so that she could ultrasound that second area she had seen again.

Justin: Ohh, yes. Oh my god. Ohh, my god.

Sydnee: So I had to go back in for a second look, which made me worry that it was something.

Justin: Ugh! I had blocked that out. Ugh.

Sydnee: So same thing again. And everybody again was very nice and pleasant about it. We waited in the waiting room afterwards. And then finally she came out and said, "It looks like a couple little lymph nodes. We're not worried. We're going to do a follow-up ultrasound in six months."

So—which is all—like, and I know this logically. That's good news. That is unlikely to be anything concerning. If you are going to do a follow up ultrasound in six months. That kind of gives you a window into how worried we are that it's something serious. If we thought it was something serious, we would probably want to do something sooner than six months, right?

Justin: Well, they can't give you what you want, which is—

Sydnee: It's still not nothing.

Justin: Well, they—and it'll never be anything. That's what you want, is "Actually, we were wrong, and we're the jerks for wasting your time for even bringing you in here. They're perfect and you'll never have any problems, ever. You never have to think about breast cancer again as long as you live." That's what you want them to say, right?

Sydnee: So, I went back just last week, on Charlie's birthday. It was—I didn't forget the exam 'cause I knew it was on Charlie's birthday. I went back for my six month follow up. And it's one of those weird things where it had been in the back of my mind every day since I had left the breast center that day when I got the ultrasound. Just, like, a low level drone in the very background. And when everything else was silent, I could hear it again. "Still got that ultrasound coming up." [laughs quietly]

Justin: I have a very similar thing for when the new Dave and Buster's is gonna open up at the Huntington Mall. It's like, when everything's quiet I'm like, "[clicks tongue] [muttering] Wonder if it's open yet. Wonder how much longer until it's open."

Sydnee: Yeah. That's just as serious as intense.

Justin: I'm just trying to lighten it a little bit, you know, Syd? Just a little bit of paprika.

Sydnee: I've already said that—the good news is, I had the follow up ultrasound last week. Everything looked identical to what it looked like six months ago.

Justin: Well, I don't wanna co-op—I guess I'm nervous—

Sydnee: And I was fine.

Justin: —as—as somebody who has been through these stories before that have not gone so well, like, ended so well, like, I don't want it to... come across that we think this compares to people who have been through—you know, we feel so fortunate. But I think it was, like... making sure that people knew that that wasn't something that—not only that ours just didn't experience, but it's kind of like worse, it sounds like, in some ways, if you let it be.

Sydnee: Well, no, I wouldn't say it's worse, though. Because when I was in a situation where I didn't know how to get an order, like...

Justin: Oh, yeah.

Sydnee: I needed an order for an ultrasound, and I wasn't sure who was gonna put it in. I had instant access to two doctors. Not instant, but within the same day. I had same day access to two doctors who were able to do that for me. And even following up—

Justin: [simultaneously] I guess I meant literally.

Sydnee: —this ultrasound that I just had done, they told me, the radiologist told me—well, the nurse told me that it was fine. I got a text from my OBGYN an hour later saying "I just got sent your ultrasound report and here's what it is and you're fine."

Justin: I meant specifically the catastrophizing. That specific waiting to find out what you need to find out. Obviously, like, it's nice that you can cut it a little shorter, maybe, you know, by circumventing. But still, like, you're not necessarily immune to—you would think as much as you have to trust statistics and, like, potential outcomes as a doctor, like, almost—most of the time, it seems like you're kind of saying, like, "This is our best option that we have available," right? Even if you know those—and you know, like... it's like when you go to get a minor, very minor surgery, but they still say, like, "Hey. Just so you know. There's always a risk with surgery."

Like, and you know that, so as a doctor you're not, like, tripping about it. But, like, it seems like... as a doctor, you... you still hear that risk. Like, that risk is still very much super-duper present to you. You can't dismiss it like you would if you were going through a, you know, a flow of symptoms and...

Sydnee: Right. No, you can't. And, I mean, I will say that there are experiences that you have that, because you see it so much more than someone who doesn't work in healthcare, right? 'Cause, like, yes, as a patient you may experience your own—whatever your own health journey is. Whether you do get diagnosed with something or you don't, or you might have a friend or family member.

As a physician, you might interact with hundreds of people who have that condition, and so you see the more common outcomes, but you also see

those rare times where something didn't seem like it was anything, and then it turned into a very big deal.

Most of the time that's not the case, right? We run the numbers and we say most of the time, when something looks like this, it's nothing. And that's usually right.

But every once in a while, it is something. And what's tough is that you can't then make the rule "We biopsy everything we ever see." Because we would do a lot of unnecessary biopsies. Occasionally those lead to harm. Most of the time they don't. But occasionally, something goes wrong.

And so then you just start compounding the harm you might cause if you go wild with testing following every single study, right? It's why we don't start doing cancer screenings when everybody's 20 and do them every six months for the rest of our lives, generally speaking.

So... I don't know. There were things about it that made it easier because of the access. I knew logically that I was okay. But yeah, I'd seen when this—people in my exact situation turned out to have a very real, serious problem.

I will say, what it reminded me—and I feel like because of the kind of medical work I do, I don't—I'm not necessarily the one who needs the most reminding of this. But... I still take for granted how even if—if I have to break some bad news to someone, or even just give them the possibility of bad news—"We got this result. It might mean nothing, but we gotta do some testing." I still think I can talk about it in a way that will make the patient feel fine. And I don't know that there's a way you can do—the best you can do is tell them the truth, tell them what the risks are, tell them what it could be. Uh, try to answer all their questions as best you can. And then give them the follow up plan.

But know that, like, they're gonna walk out of there terrified. They're gonna walk out of there wondering.

And so what you can do with that information is stay on top of it. Be responsive. Make sure that they get the next thing scheduled, that they get the results in a timely fashion, which is something we can do on an

individual level as healthcare providers, but something that our system should also be built to do. Everybody should have immediate access to, what are my results, and what are we gonna do about it next, and how fast can we get it done?

Justin: Yeah.

Sydnee: I mean, that's how the whole system should be. We shouldn't have to wait for days in fear that something is seriously wrong without knowing. So...

Justin: Well, I am beyond, uh, relieved that all is well on the breast front.

Sydnee: Yes. Yes, me too. I have been returned to routine screening, so I will get another screening mammogram next Janu—late January, early February, something like that.

Justin: Alright.

Sydnee: And, uh—and hopefully just move on from there. But I think it's a good reminder for those of us who work in healthcare how scary it can be on the other side. Um, and a good reminder that we need a better healthcare system that prioritizes... patients.

Justin: If anyone listening is in charge of the healthcare system, just go ahead and do a new one. Start over! Did you hear about podcaster Justin McElroy being stuck in the hospital for two and a half hours to make a boring appointment? Can you imagine the hours of comedy and entertainment that were just lost to the abyss as I sat there watching muted HGTV? I mean, can you imagine?

Sydnee: [laughs quietly] I'm so sorry, Justin.

Justin: Don't say sorry to me!

Sydnee: So, truly—

Justin: Say sorry to history!

Sydnee: Truly, no one has suffered...

Justin: [laughs]

Sydnee: ... more than you.

Justin: The one thing you can say about me is I always get the point of the episode. Thank you so much [through laughter] for listening to Sawbones: a marital tour of misguided medicine.

We want to say a huge thank you to The Taxpayers for the use of their song, Medicines, as the intro and outro of our program. Thanks to you so much for listening. Uh, we really appreciate it. That is gonna do it for us for this week. Until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]

[chord]

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