

When it Mattered

Episode 18: Dr. Lisa Sanders

Chitra Ragavan: Hello everyone. I'm Chitra Ragavan, and this is When it Mattered. When it Mattered is a podcast on how leaders deal with and learn from adversity. This episode is brought to you by Goodstory, an advisory firm helping technology startups find their narrative.

Chitra Ragavan: My guest today is the renowned physician, author and journalist, Dr. Lisa Sanders. She's Associate Professor of Internal Medicine and Education at the Yale School of Medicine. Many of you know Dr. Sanders from her two globally popular New York Times columns about medical mysteries; Diagnosis and Think Like a Doctor.

Chitra Ragavan: The Diagnosis column inspired the hit Fox television series, House, M.D., for which Sanders served as a technical consultant. And now a new Netflix New York Times series also called Diagnosis, showcases Sanders using global crowdsourcing to help diagnose and solve eight medical mysteries. Sanders new book Diagnosis: Solving the Most Baffling Medical Mysteries is a compilation of 50 stories from her column. Dr. Sanders, welcome to the podcast.

Lisa Sanders: Hi, thanks so much for inviting me, Chitra.

Chitra Ragavan: You majored in English in college at William & Mary, and you wrote for your school paper, the Flat Hat. And after you graduated, you became a television news producer. So what prompted you to give up television and go to medical school?

Lisa Sanders: Well, I loved television and I loved the news business, but one day... and it happened over time; nobody really turns on a dime, no matter how they tell the story. But so, one day I was out with the correspondent that I usually worked with, Bob Arnot, or at least I worked with him for years, and we were doing a story about whitewater rafting. And suddenly, he disappeared from the television monitor where I was looking at what we were filming. And we looked around and found him on the banks of this river pulling this elderly woman out of the water.

Lisa Sanders: He pulled her out and laid down, and then he did something that I had really never seen except in TV dramas. He started doing CPR; chest compressions, breathing, mouth-to-mouth resuscitation. And after less than a minute, she coughed, turned her head to the side, a ton of water came out of her mouth, and she woke up. She sat up. She was fine.

Lisa Sanders: And to me, that was just amazing. I had never wanted to be a doctor. It was not something that was on my mind. I don't come from a medical family. And so it had never occurred to me that maybe I would ever want to be a doctor. But when I saw Bob bring this woman back from death, really death, I thought, "Wow! I'm never going to do that." And it had never occurred to me that I wanted to do that, but it did plant the idea in my mind that I would like to do that. And so a couple of years later, I thought, "Well, maybe I will go to medical school." And I did.

Chitra Ragavan: So now you're in medical school and you're learning the art and science of diagnosis. How did you start to evolve your views on this technique of diagnosis, and what were your initial takeaways about it?

Lisa Sanders: Well, because I had worked with Bob, who was a doctor, I worked with him for four or five years, I felt like I got medicine. I had covered it for years. And so I didn't feel like I knew what doctors knew, but I understood how medicine worked. And the first two years of medical school are, you sit in a classroom, you listen to lectures, they tell you all the stuff you really need to know, or you cut open bodies in anatomy, but it has nothing to do with patient care. And then in your third year, you actually spend time with doctors doing what doctors do.

Lisa Sanders: And on my internal medicine rotation, I went to this meeting that everyone goes to, everyone in training and everybody who's in an academic medical center goes to called, in my institution it's called resident report, in other institutions it's sometimes called morning report. But at the heart of this meeting is a patient whose case is presented to us, the learners, the same way it presented to the doctor who admitted this patient.

Lisa Sanders: So it starts off with what we now call the chief concern, which we used to call the chief complaint; that is, why did the patient come to the hospital? And then we hear what their story is as they told it, and the additional information in their past medical history and the physical exam. And we sitting in that room hear about the patient's

story as it came to the doctor who saw them. Patients don't come with a diagnostic label on them, and often you have to put everything together to figure out what's going on, especially if they're sick enough to come to the emergency room.

Lisa Sanders: I mean, sometimes it's not hard. A guy comes in, he's in his mid-50s, he has crushing substernal chest pain and he's drenched in sweat, and you think, "This guy is probably having a heart attack." So sometimes they're easy, but often it's a puzzle. It's a mystery that has to be solved. And so I didn't know that. I thought that diagnosis was like math, four times six is always 24, so fever and rash is always fill in the blank, but it turns out it's not. It's not always one thing or the other thing. There are a lot of possibilities, and you have to figure out which is the right one. And that was different. I never knew that.

Chitra Ragavan: And you also said, which I thought was very interesting, that writing up these diagnoses was like an art of storytelling. And that's what you are doing. You are finding out and telling the story of the patient. How did you get from doing that in these medical reports to writing and telling stories for the New York Times?

Lisa Sanders: Well, of course like so many things in life, at least in my life, luck had a huge role in this. One of my acquaintances had recently gotten a job at the New York Times magazine, and he was a young guy. He called me because I was literally the only doctor he knew. And so he said, "Lisa, what kind of stories can doctors write?" And I'm like, "Oh. Well, we write this one story almost every day. And it's a great story. It's a mystery story. It's a detective story." It's a history and physical, that's what it's called in the medical jargon, but really it's the diagnostic dilemma that's being presented to us for us to solve and figure out so that we can figure out what the patient has, so that we can know how to treat them and what should happen next.

Lisa Sanders: And so my friend, Paul Tough, a wonderful editor and now a wonderful writer, was mildly interested. It was a sales job on my part. I sent him copies of the New England Journal and Mayo Clinic Proceedings, because these kinds of stories, they're what doctors tell each other. They're the stories we converse in. They're the way we think, really.

Lisa Sanders: A good friend of mine, Kathryn Hunter, wrote a fantastic book called *Doctors' Stories*. And this is like 25 years ago. She made the argument that the way doctors communicate and even understand

medicine is through stories. And so that's what I tried to sell to Paul was that this is the story of medicine, really, or the story at least of diagnosis. I was finally able to persuade him that that was the right way to tell a story.

Lisa Sanders: And I wish I could say he immediately said, "You are brilliant. Drop what you're doing and start writing this column right away," but he didn't. He said, "Thank you very much," and then he called what I consider a real doctor writer. And a few months later, I heard from him again, and he said, "It's not really working out with this real doctor writer. So would you like to give it a shot before we just give up on it?" I'm like, "Yeah," with my husband sitting next to me, encouraging me, "You can do it, Lisa. You can do it." So I said, "Yes," and he said, "Great. Can you turn something in on Monday?" It was Thursday. Obviously, this was a trauma for me.

Chitra Ragavan: What was your first column? Do you remember?

Lisa Sanders: Oh, I'll never forget it. It was a patient that I had seen. When I first started, all of them were patients that I had seen. It was a patient that I had seen, who had Munchausen's. She was a young woman who had a seizure disorder that had been diagnosed, and she took anti-seizure medicines, but she presented with tonic-clonic seizures, even though her anti-seizure medicine was at a normal level. So she was brought in after having a witness seizure in a restaurant, and we were trying to figure out why she would be having these seizures when her anti-seizure medicine, which had been fine for her for years, according to her, wasn't working.

Lisa Sanders: So we changed her anti-seizure medicine, and we were going to discharge her. Although I have to say the neurologist, after his first encounter with her after he first went into see her, he came out and he said, "These are pseudo seizures. She has a seizure disorder but she's not having real seizures now. These are fakes." I'm like, "Oh, that's impossible. This woman, she's so distressed." But the day before we were going to discharge her, I went in to tell her that we were going to send her out with this new medicine, and she was fine, and then overnight she became extremely ill. She developed high fever, her blood pressure dropped, suggesting that she had an infection in her bloodstream.

Lisa Sanders: We sent blood to the lab to be evaluated, and we transferred her to the intensive care unit. And the lab called me right away, which is very unusual, called me right away and said, "She has multiple gram-negative organisms in her blood."

Lisa Sanders: There is really only one thing that causes that. And that's if you get stool in your blood. And there's really only a couple of ways you can get stool in your blood; either something ruptures in your intestines, but she had no abdominal pain, nothing, or you contaminate own IV site, which is what she had done. She, of course, denied it. So that was my first column. I'll never forget her as a patient or writing her column.

Chitra Ragavan: And that must have been scary in a way, right? If a patient's lying to you, and which is what Munchausen's is, they're faking illness, how do you trust yourself to come up with the right diagnosis?

Lisa Sanders: So we treated her. Fortunately, somebody like her, she responded very quickly to antibiotics and she got well right away. And we asked the psychiatrist to come and see her. But of course, and this is the nature of that particular disease, she denied ever doing anything of the sort. And we did some digging into her background. There were lots of other things about her that didn't quite make sense.

Lisa Sanders: For instance, she told us what her name was and where she had been hospitalized before. When we contacted that hospital, they didn't have a patient of that name. So she said, "Oh, that's right. I changed my name because my boyfriend was stalking me." And so we used her new name or her other name, and they didn't have that patient either. When we tried to put in an IV, all of her peripheral veins were completely blown as if she'd had many, many IVs. So there were a lot of things that suggested that she was not your usual patient. This was unbelievable.

Lisa Sanders: And she left. We discharged her when she was better. She left absolutely affirming that she had never done this to herself, that she was very hurt that we accused her of this. We got a CAT scan to look for any evidence of any perforation, she didn't have one. She didn't have any evidence of that. So I think we were right. And it's sad. I think it's a pretty terrible comment on your life when you feel best when you're being cared for in the hospital. It's not a good message about your life outside the hospital.

Chitra Ragavan: In one of the early New York Times pieces, you wrote about your own efforts to find out the cause of your sister's death, and I understand she was an alcoholic. What was that journey like, and how did that change you as a doctor and a diagnostician?

Lisa Sanders: People die in the hospital. That's one of the bad things that happens in the hospital, and so everybody gets a lot of experience telling the next of kin about this terrible event. And so often, people would say, "How? How did they die?" If they got hit by a car, that's one thing, or shot, then a perfectly healthy person suddenly dies. I understand that. But often, these are people who had medical issues to begin with. I mean, that's why they're in the hospital.

Lisa Sanders: And so I always thought it was strange that this desire to know specifically, exactly, and often in ways that we couldn't possibly know what happened to bring this person to beyond what their body could tolerate so that they died. I thought it was odd. And then when my sister died, I had the exact same feeling. She was not a perfectly healthy individual. She liked to present herself that way, but she was a smoker, and she had very significant alcohol abuse problems and consequences from that.

Lisa Sanders: When I heard about how she died, she died sitting by the swimming pool with a beer and a pack of cigarettes next to her in the late morning. But what was really strange is that her cell phone was right there next to her. And I thought, "My God, what could kill you so fast that you don't even have a chance to pick up your phone and call for help?" So I was obsessed with that, just like all these other patients' families had been. And it taught me a lot about how the needs of the people who care are not necessarily reasonable. Certainly knowing doesn't change the outcome, and yet it turns out that knowing is really important. And so it changed me a lot, just in my attitude toward what patients wanted to know.

Lisa Sanders: We use ourselves as a measure all the time, and that's great as long as we have something that we can compare to. Doctors, we're legendary for using our own baselines, our own behavior as the "normal baseline". "How do you know when a patient drinks too much?" "When they drink more than their doctor." That's a joke, right? But it's actually kind of true. We often use ourselves as what is normal. And so if somebody reacts in a way that you wouldn't predict yourself to react, you think that's abnormal. So I learned that their reaction was not abnormal, but extremely normal. And it was humbling to be reminded or shown that using myself as the measure isn't it going to be 100% accurate or even close.

Chitra Ragavan: How did your column turn into a Netflix series?

Lisa Sanders: A producer in New York named Scott Rudin turned out to be a fan of my column. I've written it since 2002, so I've written it for a long

time. And so he contacted the New York Times and said, "Let's make this into a TV show." He was not the first person to contact me about turning my column into a TV show, but the others who wanted to do it wanted to do it in a way that was boring, had already been done.

Lisa Sanders: The usual way people suggested taking my column and moving it to television would be to take my actual columns and do reenactments with the patient's voice-overing them. Well, first of all, somebody had already done that without my help, just completely independently, because once you publish something, it's out there for the world to use, a show called Mystery Diagnosis. And it was just fine. I mean, I didn't have anything to do with it except that I found these stories.

Lisa Sanders: And it was perfectly fine television, but not the kind of television that I thought was particularly interesting. And so all the other people who had contacted me wanted to do that. That was not interesting, not to me, and fortunately, not to any broadcasters.

Lisa Sanders: Scott was interested in doing something different. And so doing something different gave us permission to do something really different. And so we came up with the idea of crowdsourcing as not the way to make a diagnosis... just because it's on a list of possibilities doesn't mean that it's the right answer, but it's the beginning of looking for a diagnosis.

Chitra Ragavan: And of course, we have to note here that Scott Rudin is the Scott Rudin, who's this extraordinarily successful producer. He's won 15, Tony awards on Broadway, and an Emmy, and a Grammy, and an Oscar to boot, a rarity in the industry. So you are in pretty good hands.

Chitra Ragavan: And I binge-watched the series last week. And initially I was a little bit skeptical, I guess, on how this whole crowdsourcing experience would be both for the patients and for the doctors who are treating them. But about a couple of episodes in, I started to see the incredible power behind what you were trying to do, which in your own words was, trying to expand the size of the room in which these diagnoses take place. Talk a little bit about that, because most people think of doctors making individual diagnosis, but actually, often you say it's a collective process, and that's where sometimes the best diagnoses occur.

Lisa Sanders: Right. Any honest doctor will tell you that when they come up against something that they haven't seen before, they're not certain about, they will always turn to what I call and what many people call, the smartest doctor in the room. So we all have in our heads the list of people who we know to be outstanding diagnosticians. And if you have any brains at all, you will try to become friends with them so that you can pick up the phone when you see something you don't understand and say, "Hey, André, do you have a few minutes to talk to me about this interesting case?"

Lisa Sanders: And even when you don't do that, even when you see something that's more ordinary but you're just not sure, you always turn to the other doctors around you and go, "What do you do when you see something like this?" So informally getting a second opinion is standard practice for doctors, but you're limited by who those doctors are, I mean, who you have access to. And I thought crowdsourcing would allow us to have really the widest possible reach. Also, I thought it would give us an opportunity to let people besides doctors, weigh in.

Lisa Sanders: There's lots of ways to know things. Some of the earliest research in diagnosis show that the person most likely to make a difficult diagnosis is the person who's seen it before. Well, it's not only doctors who have seen it, whatever "it" is before, the patients themselves, their family, other caregivers. There are lots of kinds of people who have seen this before. Plus, I think nowadays, patients are pretty good, some of them anyway, at Googling their own symptoms. And so I was interested in hearing from as wide an audience as possible.

Lisa Sanders: One of the columns that I wrote for five or six years called Think Like a Doctor, did something like this. I used solved cases, and I would present them as if they were a mystery right up to the point before the doctor make the diagnosis, and I would stop and say, what do you think is going on? And so these were long columns. I embedded medical records, de-identified of course, and people would go through them. And it was really amazing.

Chitra Ragavan: You've also gotten some criticism for taking this approach of global crowdsourcing, in essence allowing not just doctors but other lay people to speculate on what these conditions might be. What do you think of those criticisms?

Lisa Sanders: I don't know why people would be against getting as much data as possible. Just because somebody suggests something, it doesn't

mean that I, or the doctor, or the patient have to follow it. And I think acknowledging that there are different types of knowledge and different levels of understanding, that's what we're doing with this crowdsourcing. We're acknowledging that there are different ways to know the same kind of information.

Lisa Sanders: I think one of the reasons that people criticize that is that they think it devalues what the doctor does. I disagree. You can make a suggestion, and patients often do. Patients often say, I think I have X, Y or Z, and you can either agree with them or disagree with them, but you listen to them and hear what they have to say, because it might tell you something about who they are and how they understand the world. But I don't think it's any different to open this up broadly.

Lisa Sanders: It seems like an empowering thing to give patients and family the opportunity to exhibit their very real knowledge on a topic. So I understand that it's new and different and people don't like new and different, or some people don't like new and different, but I think it's an experiment worth trying.

Lisa Sanders: Now, what I don't think is I don't think that crowdsourcing like this, global crowdsourcing is going to be the way people make diagnoses. To me, it was more of a metaphor than an actual practice. I think it would be very hard to implement something like this on a regular basis to use routinely with patients. I mean, we all do it in our own way.

Lisa Sanders: One of the people that I wrote about, this marvelous doctor in Minnesota, would have what he called diagnostic flash mobs. So when he had an interesting or difficult patient coming to see him to get a diagnosis, he would send out an email to his 50 or so colleagues and say, "Thursday at 4:00," or whatever, "I'm going to present this patient. I would love to get your input." And whoever was free then who was interested would come, and they would walk through, talk through, think through a patient as they presented. So we use this in various versions. I think people are just upset that I invited patients in to the conversation as well.

Chitra Ragavan: I watched the series last week, and it's pretty nerve-wracking to watch because some of these stories are not only heart-wrenching, but you're in the room with these patients as they're having these very rare disorders. You have someone like Angel, who at age 23 has such extreme muscle pain that she can't move. Or Sadie at age seven, who's facing this devastating brain

procedure for her frequent seizures, which might involve losing half her brain. Or Willy at age 56, who's literally losing his memory day by day. Or Kamiyah at age six, who has seizures that make her go limp like up to 300 times a day. These are just some of the examples.

Chitra Ragavan: And what I felt like was, if you're an average patient, let's just call it that for a minute, who has pretty much one of these; we know so much about medicine, and if you have one of those conditions that's known to doctors, then you're in pretty good shape. And if you have one of these rare disorders, then good luck to you, because some of these patients have been battling these extraordinarily difficult conditions for more than a decade in some cases.

Lisa Sanders: Right. It is hard to watch it. You can only imagine how hard it must be to live it. Because I've written this column for the New York Times, I've gotten letters, usually I get five or 10 a week, recently I've gotten a lot more, but of people who are so frustrated because they have symptoms that the doctors they've gone to see have not been able to diagnose; or I think just as commonly, people have gotten a diagnosis, but either they don't like the diagnosis or they don't believe the diagnosis.

Lisa Sanders: I mean, Lashay is a perfect example of that. She was somebody, a young woman, who developed this problem which she describes as vomiting, but if you see it, you can see that it's not really vomiting, it's regurgitation. She developed this after having an infectious diarrheal infection when she was traveling. So she had this diarrheal disease. It lasted three or four days. And then after that, she developed this very strange symptom of regurgitating everything she ate or drank. It's quite unusual.

Lisa Sanders: Here's what you need to know is, actually having a diarrheal illness or any kind of viral GI illness can change the way your body's GI system works. That happens up to 25% of the time. So they don't all get what she had, this regurgitation, but they all had something. But because of the way it was presented to her dismissively as if she were in charge of it, as if she was doing it to herself, she refused to accept the diagnosis, and so did your family.

Lisa Sanders: So I would get a lot of these emails of people who either don't have a diagnosis, or don't like the diagnosis, or don't accept the diagnosis, and the diagnosis isn't always right, so sometimes they're right to do it. So I knew that there was a need to have this

addressed in some way. And I feel like this show allowed us to talk about some of those difficult diagnostic dilemmas and what happens to those people.

Lisa Sanders: I think it's a very lonely feeling. People would often write to me and say how isolated they feel, like how alone. From their perspective, all of their friends go see a doctor, the doctor says, oh, you have this, and gives them a pill and then they're fine. That's the perception. When you're different, you feel alone. That's what I think they were feeling.

Chitra Ragavan: That was one of the unexpected benefits that I found was so touching in the series was this release from the sense of isolation and this knowledge that, all of a sudden, they had a global community, someone they felt actually cared for them. Kamiyah and her mom actually traveled halfway around the world to meet another 12-year-old boy, to Copenhagen, just to see what his life was like. And did you ever anticipate the depth of the emotional bonding and comfort that would come from this series?

Lisa Sanders: No. And really, that episode in particular, it changed our sense of what we were doing, because when we started filming Kamiyah, she still didn't have a diagnosis. We knew that she'd been to see the NIH and the NIH hadn't been able to do anything, and so we were going to see if the crowd could provide her an answer. But actually, the NIH had come up with something. There was a delay in them letting her know.

Lisa Sanders: And so what Kamiyah's mom found out is that Kamiyah, her beautiful baby, had this extremely rare genetic abnormality. And so we decided, Kamiyah's mom, we said, "What can we do now? Now that you have an answer, what can we do?" And she said, "I want a village. Hillary Clinton says, "It takes a village to raise a child." I don't have that village. Everybody looks at my child like she's odd, and she is. I need my own village." And so we put her case out there, and asked for people who knew something like this to contact us and let us create a community for her. And that's what we did.

Lisa Sanders: And so the child she went to visit in Denmark had not only the same genetic abnormality that she had, but the same presentation. And so really, there are only two or three people in the world that we were able to find, or that the NIH was able to find with a similar presentation. And so she went to see a third of her community by going to visit this boy.

Chitra Ragavan: And what was interesting about that is that she was able to see, and her mother was able to see how the disease progresses. For instance, in the boy, Altes, who was 12, there were fewer seizures, but they could last as long as five minutes. Whereas with Kamiyah in the state that she's in now, they last a few seconds. And so at one point, it makes her mother stop and take stock of the situation and say, "Five minutes. That is a very, very long time." But it also helps patients like that and their families plan for the future to know what's coming down the pike, especially in these rare disorders.

Lisa Sanders: Right. And Kamiyah's mom was very concerned about that, like, what does the future hold? I mean, and when she saw these episodes, they scared her. You could hear Kamiyah breathing, but her thought is, "If everything's losing strength, is she going to keep breathing? Is her heart going to keep beating? I mean, is she going to die when she has one of these episodes where she just goes limp? Is everything going to stop working?"

Lisa Sanders: And I think it was reassuring to her in some ways to see that there were children who lived well beyond; Kamiyah was six, the young boy was 12, so going to live at least that long. And I think it's important to know what the future holds. That's one of the important purposes of getting a diagnosis is to understand what the future holds.

Chitra Ragavan: I just want to stay with Kamiyah for a minute for one last question, because it was such an extraordinary case because it wasn't just her family, suddenly she and her family feeling connected by understanding there are other people out there. But I realized often, it's scientists who are working often for decades on these problems without knowing, working on it from an academic and clinical perspective without understanding that there are actually patients out there who could benefit from this rare disease.

Chitra Ragavan: And I think it was in this case where you saw Dr. Andrea Meredith of Meredith Labs, who actually burst into tears when she realizes, "Wow! There's someone I can actually help. I've spent my entire career on this very narrow scientific research on this very rare disorder, and there's actually an outcome that could be positive."

Lisa Sanders: Yeah. That was amazing to find out. I mean, no one, certainly nobody on my team expected that we would find someone who was doing this exact research. I mean, that was amazing. That was well beyond anything we had hoped for. It's a source of hope. As her mom says, it might not help Kamiyah, but it's good to know

that it might help somebody in the future. It might help Kamiyah. We hope it helps Kamiyah, but she accepts that it might not.

Chitra Ragavan: You also saw what do you call the darker side of crowdsourcing in the case of a teenage patient, Lashay, who the crowd diagnosed with potentially having that regurgitation syndrome. And some of the comments that were coming in were very negative, because often as you said, with teenage girls particularly, these types of conditions and problems are associated with bulimia and things like that. And you saw the darkness of some of those comments coming in.

Lisa Sanders: Well, I actually learned a lot from Lashay's case. First of all, I thought, "Well, maybe bulimia could present this way." And I got so many emails that said, "Are you kidding? Nobody that has bulimia goes to the emergency room. Don't be ridiculous." And I thought, "Oh. Yeah, that's probably true." I don't know why she got such a rude reaction from so many people. I mean, I guess because she's a beautiful girl. When she's not acutely suffering, she looks like she's fine. I don't know why that makes people crazier than somebody else, but it clearly did, and there was so much hostility directed at her. It was shocking to me that she was treated so badly.

Lisa Sanders: But that was a small minority of the responses. Most of the responses were very kind, and thoughtful, and caring, and concerned. That it was even a small percentage was shocking and upsetting. But really, the vast majority of people who responded to her responded to her suffering and accepted that she was suffering. Many people who had what she was diagnosed with, Rumination Syndrome, reached out and told described their own journey of accepting this diagnosis, which is always difficult, and the treatment, which is not pleasant at all. But she got a lot of support from that.

Chitra Ragavan: You talk a lot in the series about the lack of salesmanship, for lack of a better word, in how doctors break bad news to patients. And you told me that you had a similar experience with your dad when he found out about your mom's health, and how that news was broken to him. Can you talk briefly about that?

Lisa Sanders: Yes. So my mother one Christmas developed a really bad cold or cough. I mean, she was a smoker, so she got this really bad cough. And when I left her a couple of days after Christmas, she looked just awful, but she didn't want to go to the doctor and she

certainly did not want to go to the hospital. But on New Year's Eve, my father was finally able to convince her that she needed to go to the hospital. She was quite sick. He had to help her into the car and help her into the emergency room.

Lisa Sanders: She was taken in right away, and they said, "We're going to get her hooked up to IVs and get her in a gown, and then we'll come and get you when she's ready." And my father was waiting in the waiting room. And after a surprisingly long period of time, the doctor came out and said, "I'm sorry, she's gone." And my father looked at him and said, "Oh, don't be ridiculous. Where could she go? I have the car keys."

Lisa Sanders: And the doctor at a loss for what to say next, just repeated, "She's gone." He couldn't bring himself to say the word died or dead, or even passed away, gone was all he could say. And it took a horrifyingly long time for my father to accept that because it wasn't even on his mind. We thought she had a cough or maybe pneumonia. There was no idea that she could be at death's door.

Lisa Sanders: That taught me a lot about some of the important things in medicine. And one of the important things in medicine, perhaps one of the most important things in medicine is to be able to communicate clearly and honestly, and at a level that people understand you. We didn't used to teach that at all. I think we have started teaching it. But let me just say, most doctors out in the world have either learned it on their own, or happened to be gifted with this, or just continue to be terrible at communication. And that's terrible.

Lisa Sanders: What's the good of knowing something about how somebody's body works if you can't tell them what it is and how they can fix it?

Chitra Ragavan: Well, Dr. Sanders, it's been so amazing to have this conversation after all these years of reading your columns. Thank you so much for joining me.

Lisa Sanders: Well, thank you so much for inviting me. This has really been such a pleasure. Thank you.

Chitra Ragavan: Dr. Lisa Sanders is Associate professor of Internal Medicine and Education at the Yale School of Medicine. She writes the Diagnosis column and Think Like a Doctor Well Blog column in the New York Times. And if you haven't already checked out her Netflix / New York Times series Diagnosis, I highly recommend it.

It's an incredibly thought-provoking look at the benefits and perils of crowdsourcing when making diagnoses.

Chitra Ragavan: Thank you for listening to When it Mattered. Don't forget to subscribe on Apple podcasts or your preferred podcast platform. And if you liked the show, please rate it five stars, leave a review, and do recommend it to your friends, family, and colleagues.

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