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UNDER MY SKIN

A Pinch of Assault

I've just desiccated a tag on Reba's eyebrow. A moment later she says, "Ah, now my skin is starting to feel numb. Too bad I don't need it to be numb now." Then she pauses for effect: "Maybe next time we can wait for the anesthetic to start working."

Ouch.

Picture yourself walking down the street. You approach a passing stranger and stick a needle in his forehead.

Picture yourself at a party. At a conversation by the punchbowl, you spray a neighbor's nose with nitrogen.

Now picture yourself in handcuffs at the police station being arraigned for assault.

Hurting people is a routine part of our day; it's therefore worth a moment to consider that without an unstated social contract that lets us get away with (and charge for) this, the kind of assaults we commit would be actionable in any other setting.

This helps explain the way some patients react, even when—as in Reba's case—they didn't feel a thing.

Faced with the prospect of our imminent attack, people respond in several ways:

► **Terror.** "Will it hurt?" Well, of course it will, and they know it. Our usual breezy assurance ("Just a little mosquito bite!") tends to lack credibility.

► **Apology.** "I'm a *terrible* patient, Doctor." Consider the implications of this admission: We are about to stab, freeze, or broil, and *they* are running themselves down. Maybe we're the ones who should say, "I'm a terrible doctor, Patient."

► **Interrogation.** To forestall our onslaught some people resort to delaying tactics by asking questions like, "What kind of anesthetic do you use?" or "How big is the needle?" Children especially like this ploy: "Wait! What's that thing at the end of the bottle?" "Wait! Wait! How many seconds will you be freezing it?" (I usually say "6.2 seconds!" and do the deed while they're trying to figure out what I meant.)

► **Scolding.** The occasional patient likes to frame the issue in sociopolitical terms by delivering a little lecture on patients' rights and physicians' duties. "Doctor, I have a right to know *exactly* what you're doing, so you need to tell me *everything* you're going to do, step by step, *before* you do it." ("Now I am putting a 20-gauge needle onto the end of the syringe. Now I am holding the bottle of lidocaine upside down. Now I am …"—by this point they usually ask me to just get on with it.)

It's clear that all these questions, apologies, and demands are mostly declarations of fear and pleas for clemency. Although we can't, of course, grant a complete reprieve, all of us have methods for making things easier. We've all been using them since medical school: calm reassurance, testing numbness before needling, injecting slowly, and so forth. These don't take a lot of time, but since like all dermatologists I'm always in a rush, I have to remind myself to slow down and use them.

One exception is when assaulting children too young to reason with and too big to hold down. For these, I've found that it's often best to get things over with, pronto. More talk just makes for more terror.

It also seems that many people find it comforting to learn that our desiccation electrodes do not actually penetrate the skin. It's not just the fear of pain that frightens people (myself included) but the prospect of penetration that violates our body's integrity. Think about it by visualizing a needle heading your way, or try telling your patients, "The electric needle doesn't actually go in—it just touches you on the outside." Likewise, adhesive bandages help kids by shielding them from having to look at the way we've insulted their bodies by breaching its outer boundary.

Overall, it's perhaps worth keeping in mind that our procedural assaults are not just painful but scary and insulting. Anything we do to ease that is worth trying.

Meantime, we can celebrate the license society grants us to prick, prod, and poke people with impunity. Not only that, when our assault makes patients flinch, *they* apologize! ■

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