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## The stories they tell: How third year medical students portray patients, family members, physicians, and themselves in difficult encounters

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### ABSTRACT

**Background:** Physicians have long had patients whom they have labeled “difficult”, but little is known about how medical students perceive difficult encounters with patients.

**Methods:** In this study, we analyzed 134 third year medical students’ reflective essays written over an 18-month period about difficult student–patient encounters. We used a qualitative computerized software program, Atlas.ti to analyze students’ observations and reflections.

**Results:** Main findings include that students described patients who were angry and upset; noncompliant with treatment plans; discussed “nonmedical” problems; fearful, worried, withdrawn, or “disinterested” in their health. Students often described themselves as anxious, uncertain, confused, and frustrated. Nevertheless, they saw themselves behaving in empathic and patient-centered ways while also taking refuge in “standard” behaviors not necessarily appropriate to the circumstances. Students rarely mentioned receiving guidance from attendings regarding how to manage these challenging interactions.

**Conclusions:** These third-year medical students recognized the importance of behaving empathically in difficult situations and often did so. However, they often felt overwhelmed and frustrated, resorting to more reductive behaviors that did not match the needs of the patient. Students need more guidance from attending physicians in order to approach difficult interactions with specific problem-solving skills while maintaining an empathic, patient-centered context.

### Introduction

Physicians have long had patients whom they labeled difficult (Groves 1978; O’Dowd 1988). Clinicians report between 15% (Jackson & Kroenke 1999; An et al. 2009) and 18% (Hinchee & Jackson 2011) of their patients as falling into this category. Up to 40% of doctor–patient encounters may involve some level of conflict (Weingarten et al. 2010). Patients perceived as difficult are associated with provider burn-out, frustration, and poorer short-term outcomes (Hinchee & Jackson 2011), although not necessarily with poorer long-term outcomes or decreased quality of care (Perry et al. 2013).

“Difficult” patients have been characterized in various ways. Research suggests often they are patients with psychiatric disorders, multiple symptoms, poorer functional status, unmet expectations, and high utilization of health care services (Edgoose et al. 2014). The “hateful” or “difficult” patient may be angry, argumentative, mistrustful, anxious, or depressed (Strous et al. 2006; Hinchee & Jackson 2011). They may also be noncompliant, resistant to forming a therapeutic alliance, and challenge the physician’s care plan (Wasan et al. 2005). The designation of “difficult” includes “patients who make repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care” (Haas et al. 2005). A different study identifies “difficult” patients as “invalidating, demanding, disruptive, attention-seeking, annoying, and manipulative” (Knesper 2007). Certain categories of patients (i.e. drug addicts, non-adherent patients,

### Practice points

- Students often perceive patients who present as angry, noncompliant or talkative as “difficult”.
- Students often report feeling anxious, overwhelmed, or frustrated in response to such patients.
- Students often engage in empathic, patient-centered behaviors; but also resort to routine questions and actions even when these are not appropriate.
- Students want to be patient-centered, but feel they are not sufficiently prepared to know how to do so.
- Medical educators/preceptors should consider nurturing critical reflection capacity through such methods as Balint groups or narrative medicine.

the homeless) elicit feelings of frustration, anger, or resentment in many physicians (Higashi et al. 2013).

Examining this extensive and ill-defined laundry list suggests that “difficulty” may reside not only in the patient, but also in the physician, although in difficult encounters physicians always attribute the problem to the patient (Mas et al. 2009). It is worth noting that “difficult” patients are almost always those who raise negative feelings in the clinician, such as frustration, anxiety, guilt, and dislike (Strous

et al. 2006). There is considerable evidence that when patients express negative emotion, physicians tend to withdraw, paradoxically escalating difficult behaviors (Mjaaland et al. 2011). It has been pointed out that these strong negative emotions often result in patient blaming strategies, attributing annoying behavior to defects in personality, moral compass, or willpower (Park et al. 2014). Physicians can be quick to make evaluative judgments of patients' motives, legitimacy of symptoms, and congruence between physician's and patient's conceptual models of illness (May et al. 2004). Scholars have observed that when patients do not validate physician competence, physicians feel undermined (Shaw 2004; Hill 2010). All these suggest that the concept of the "difficult" patient is at least in part socially constructed (Rouse 2010).

Learners have even more difficulty than experienced clinicians in dealing with "difficult" patients. Medical students and less experienced learners identify one-quarter of their patients as difficult (Barnett et al. 2004; Hinchey & Jackson 2011). Yet we know surprisingly little about how medical students perceive "difficult" patients and themselves in relation to these patients. One useful source of data about students' attitudes toward perceived difficulty in clinical encounters is through their reflective writing.

In recent years, medical education has begun to incorporate reflective writing into student training. Medical educators are interested in reflective writing as a means of deepening empathy (Pederson 2010), enhancing learner wellbeing, and stimulating critical thinking (Wald & Reis 2010). The literature examining the use of reflective writing (and other reflective practices) during a variety of preclinical and clinical experiences (Rucker & Shapiro 2003; Fischer et al. 2008, Fischer et al. 2011) concludes that students used assignments to reflect on professional development, relational issues, retaining humanistic attitudes, patient care, understanding the patient's experience of illness, dealing with complexity and uncertainty, and coping with professional and personal stress (Svenberg et al. 2007; Nevalainen et al. 2010).

The purpose of this study was to investigate third year medical students' perceptions of their interactions with "difficult" patients as expressed in reflective essays. As these essays were a required element in a required seminar, student permission was not obtained for their analysis. After appropriate blinding of essays, the study was retrospectively reviewed and approved as exempt by the University of California Irvine Office of Research as well as the Family Educational Rights and Privacy Act Regulation (FERPA) representative who safeguards student privacy in academic settings.

## Methods

All third year students enrolled at this public medical school rotate through a four-week Family Medicine clerkship in groups of approximately eight students, during which time they are placed with family physicians in various universities and affiliated outpatient clinics. At the end of the clerkship, students write a one-page essay reflecting on a difficult student-patient encounter. Directions are intentionally open-ended: "Write a brief reflection about a difficult interaction with a patient. A 'difficult' encounter may be one in which

you experienced negative feelings (frustrated, sad), positive feelings (challenged), or both; and/or describes a situation which had an unsatisfactory outcome or posed a challenge, or one in which there was a barrier of language, culture, or class". Student essays were examined for an 18-month period until theoretical saturation of the data was achieved, i.e. no new themes were identified.

## Data analysis

Two pre-med, post-baccalaureate students were trained in the use of the qualitative data management system Atlas.ti (Friese 2011), developed to systematically analyze relationships found in unstructured data. We employed a variant of grounded theory analysis (Strauss & Corbin 1997; Charmaz 2006), immersion/crystallization (Reis et al. 2007), which involved close reading and re-reading of students' essays. Student coders were guided by the following set of research questions: (1) How do students portray "difficult" patient encounters and/or difficult patients? (2) How do students portray themselves in these encounters? (3) Do students or patients change from the beginning to the end of the encounter?

Using five essays, the coders worked with the lead researcher to develop a codebook for categorizing individual words and phrases related to the above research questions, as well as relevant demographic information. In identifying initial codes, we attempted to stay as close as possible to actual words used by students, rather than impose interpretation. One thousand and twenty one initial codes were identified. Codes were revised and modified in an iterative process that involved both ongoing coding and identification of new codes as needed. Essays coded earlier were reviewed to ensure inclusion of more recently discovered categories. Based on team discussion, codes were then grouped into super-codes, representing major themes related both to the initial research questions and to frequently endorsed concepts that emerged from the data. One hundred and seventy two super-codes were identified. Each essay was coded for as many themes and subthemes as were present in the essay. Frequent team consultation occurred regarding coding questions throughout the coding phase of the project. Consensual resolution was achieved in each case.

## Results

### Description of sample

One hundred and forty four third year students participated in the family medicine clerkship over the year and a half period (July 2012 to December 2013), and 134 (93.1%) submitted essays. Students who did not submit essays were excused from the assignment for a variety of personal reasons. For those essays where gender of the student could be determined (124), there was an equal division between male and female.

### Patient demographics

Eighty eight essays noted patient age. Of these, the majority were described middle-aged (41) and elderly (28), with the

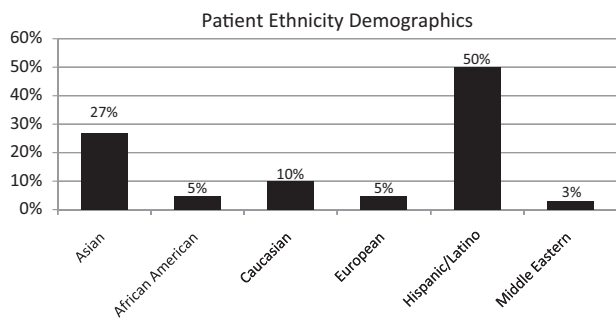


Figure 1. Patient ethnicity.

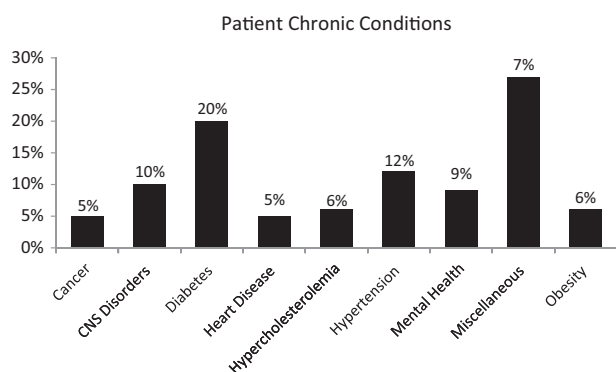


Figure 2. Patient chronic conditions.

remainder being adolescents, children, and infants. About 45% of the essays mentioned patient ethnicity. Of these, half were Latino (Figure 1). The majority of patients described were female (59%). The primary reasons given for the patient visit and/or chief complaint were pain (44), health maintenance (28), and mental health issues (27). There was a wide range of additional chief complaints/reasons for visit. In addition to their presenting problem(s), patients also had a large number of chronic medical conditions (229 mentioned) (Figure 2).

### How students portrayed patients

Students made many general observations (276) about their "difficult" patients, as well as noting specific nonverbal (69) and verbal (179) patient behaviors (Figure 3). Students portrayed patients most often as angry and upset (101 comments). "The patient was angry and combative on hearing provider recommendations" (P68); "I met with a patient who was very hostile to me...her hostility was hard for me to take" (P17); "He stood up and stormed out of the room saying that he will never return to this clinic and how we are all horrible doctors" (P78). Closely following this were comments describing patients as refusing treatment and generally uncooperative (87). "When patient was educated as to the beneficial effects of blood pressure control, cholesterol control, diabetes monitoring and control, and the true side effects of his medications he still refused to restart any of his old meds" (P12); "As I walked in the room, it became obvious that he didn't want to be here" (P76).

Students also frequently commented negatively about patients who shared personal stories, expressed worries about family members, and in general talked too much (50). "It was very difficult to communicate with him because he always wanted to tell stories. When I needed to know a simple yes or no, or a few word answer I would get a long

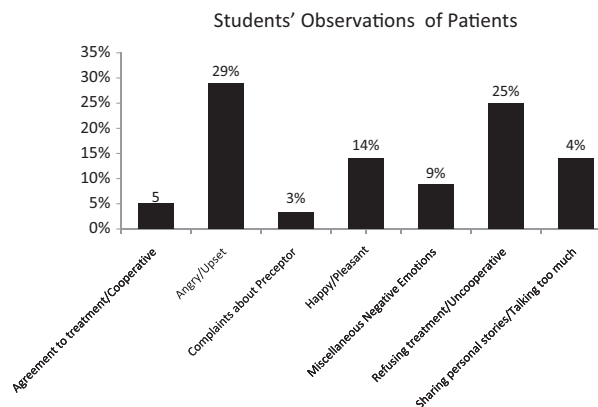


Figure 3. Students' observations of patients.

description with a story, usually involving women and bars. My interview with the patient took a very long time, and I was very annoyed and discouraged because I felt like I couldn't make any head way" (P35). They also described patients as fearful, worried, uncomfortable, or uneasy (38). "She felt alone and scared as if she were isolated from the world and her family because of this" (P11); "She was just too scared to check (her blood pressure and sugars)" (P75).

Students commented on patients' withdrawal or disinterest in treatment as well (32). "No matter what I ask, he is just too disinterested in his health..." [P126] They also noted 48 examples of negative emotions: "She started to cry again" (P7); although students were writing only about difficult patient encounters, they noted 49 instances of patients being happy and pleasant: "She was...overall rather pleasant" (P114); "When I woke him, he was...happy to see me." (P59); "She was very receptive to being part of my medical education" (P122); and 15 examples of patients expressing appreciation: "She was extremely thankful" (P11). They also recorded 16 incidents of patients agreeing to treatment.

### Patient developmental arcs

Developmental arcs referred to a shift in the patient's demeanor over the course of the encounter. Thirty-one essays (23.1%) described such movement. More than three-quarters of these shifts (24) were in a positive direction, such as moving from being upset to being more confiding ("This encounter that started out with an upset patient ended up with me gaining his trust" [P131]); from being resistant to being more amenable to speaking with the medical student ("I saw his face lit up, and I felt like he(sic) was calm and willing to talk to me." [P50]); from refusing to accepting treatment ("After discussing these matters with him, he seemed to be more amenable to a more simple regimen for diuresis and volume control as long as we could reduce the pill load" [P32]); from being upset to less confrontational ("I explained to the patient the doctor was late because of some earlier appointments that required more time...after this conversation, the patient was less confrontational" [P3]); from being anxious/afraid to being less anxious, and from having little to no understanding of their diagnosis/prognosis to having improved understanding. The most common positive to negative shift was from the patient initially being happy and pleasant to becoming frustrated and angry: "As soon as the resident physician

came in she broke down in tears, she was not the same funny patient I was interacting with" (P22).

### How students portrayed family members

Students rarely commented on family's presence, although because the assignment occurred during a family medicine clerkship, students may have been regularly exposed to family members. When students made general observations about the patients' family (36), the large majority of comments (22) were negative. "Mother was in the room and seemed to be angry...afterwards, the resident described the mother's presence as 'horrible'" (P80). "The husband at that point got on the phone and began screaming to their daughter about the 'poor service' and incompetence of the doctors in the clinic" (P89).

### How students portrayed preceptors

Very few preceptor interactions with patients were recorded (17); the majority (11) was patient-centered: "I was very happy that the physician was able to help her and that she felt comfortable enough to engage with the physician and open up to him..." (P11). But negative ones were also noted: "He had recently been diagnosed with colorectal cancer. Thus, he was in the middle of asking a question when the chief resident simply ignored the patient's question and walked out of the room. My colleague and I...watched in surprise" (P110). Very few preceptor verbal interactions with students were noted (16). Interestingly, the majority of these comments expressed negative views of the patient the student had seen or was about to see (10): "Dr. X told me she has always been a non-compliant patient" (P75). Very few essays commented on students' perception of the preceptor (9), but two-third of these perceptions were negative: "I presented the patient to him, and he merely refilled her prescription and provided her with a glucose meter, seemingly oblivious to any of the socioeconomic information I had presented to him" (P52).

### How students portrayed themselves

Students reported a large number of their own nonverbal (95) and verbal actions (161), as well as describing their state of mind before and during patient encounters (Figure 4). Only a small number of essays (19) described students' state of mind and/or emotions before the encounter. Most of these reported anticipation of difficulty: "I braced myself before entering the room, thinking to myself, here I go again with yet another noncompliant patient" (P52).

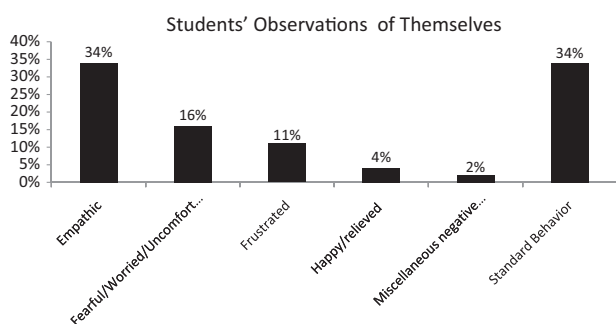


Figure 4. Students' observations of themselves.

During the encounter itself, students used the largest number of descriptors to portray themselves as empathic (116), either expressing nonverbal or verbal empathy or efforts to connect with patients. "Our eyes momentarily met. I slightly nodded my head up and down in the spirit of empathy." (P13). "I commiserated with her by offering my hand..." (P101). "You seem very angry, can you tell me more about why you are so upset?" (P44). "I thought, 'I can relate to him. I'd hate to be stuck here, too' and I proceeded to tell him that" (P59).

An almost equal number of words and phrases showed students engaging in what we labeled "standard behavior" – routine history questions, explanations, instructions, reading the chart, performing a physical exam that were often not appropriate to the mood or presence of conflict in the room: "He immediately took offense upon asking him the standard 'What brought you to the clinic today?' He yelled...my response was just as standard as my first question" (P4). "Knowing not how to proceed, I turned to filling the void with explanation. I summarized to her what I thought was going on" (P66).

The personal emotions students most frequently noted were a constellation of being anxious, worried, scared, confused, overwhelmed, and uncomfortable (55): "I was very confused and did not know how to answer that question" (P19); "I scribbled notes, internally overwhelmed and outwardly trying to remain composed with the poker face that I don't have" (P41). Students also reported being frustrated (36): "I have to admit at times I did feel frustrated because I felt I couldn't get through to him" (P64); "It was tough for me because I felt like throughout the whole encounter, I was trying to be extremely compassionate, but it wasn't always working" ([111]); as well as a small number of other negative emotions. Students rarely reported positive feelings, with the majority of these being happy, relieved, or optimistic.

### Student predicaments

Students sometimes brought up the predicaments they faced with patients (41). The largest number had to do with patient management (18) – i.e. students had to explain the nature of the disease to the patient ("We learned that she did not understand the impact of healthier diet alternatives and appropriate lifestyle modifications" [P22]); they couldn't "make" the patient accept treatment ("I politely and respectfully asked him if he would consider trying prescription medication to which he politely responded, 'No'" [P95]); or they could not manage patient's anger ("His angry and hostile attitude was something that I had never experienced before when working with a patient...I quickly left the room" [P44]). Other predicaments consisted of communication challenges (14), such as wondering how to focus a rambling patient ("I didn't know how to focus an unfocused patient (especially an interrupter)" [P82]); how to overcome a language barrier ("How could I expect myself to speak to someone about their stage IV cancer in English, let alone in Spanish? I was over my head in this one..." [P55]); not knowing how to get an interview to flow smoothly ("At that point I could feel the lines of communication shutting down" [P21]); not knowing how to confront or challenge a patient ("On one hand, it would seem so easy to tell such

patients that we've held up our end of the bargain, and now it is up to them to follow through..." [P76]. Occasionally, students expressed their dilemma as a difficulty in empathizing with the patient or holding negative, judgmental attitudes toward the patient (9): "I found it difficult to remain unbiased to someone that seemed to want to cheat the system by skipping her appointment" (P81).

### Student developmental arcs

Only 16% of the essays (21) described a developmental arc for the student. These were split almost equally between negative to positive movement (frustrated to satisfied; confused to understanding; uncomfortable to not anxious) and positive to negative (motivated/excited to frustrated/helpless). An example of the former follows: "I started to get drawn into a pattern of negative thoughts, but decided that this would only make me feel worse about things, so I started to ask myself what are some of the positive things I can do for patients?" (P44). An example of a negative arc is the following: "I was hopeful that I would be able to connect with him enough, or empathize with him..., or at the very least motivate him with some information. However, I became very frustrated when I was not able to convince him even after listening to his concerns" (P5).

### Reflections post-encounter

For the purposes of analysis, reflection was defined as a post-encounter assessment of lessons learned (Figure 5). There were 245 examples of reflection. The largest number of comments (46) emphasized the importance of practicing patient-centered medicine, even when the patient interaction was frustrating: "The patient is truly more than just their symptoms and disease process." (P111). "Casting away preconceived notions about what patients should believe or understand or how they should behave and accepting each patient without judgment is essential in providing effective medical care" (P90). "To me, the valuable experience here was that some 'unreasonable' patients have reasons for their behavior...once we got to the root of his anxiety and feelings of helplessness, he became an 'easy' patient" (P59).

Many comments emphasized the value of empathy (37); and the importance of building relationship with patients, even in difficult circumstances (17). "I heard her crying out, in search of an answer, and I tried to take some of her suffering upon myself" (P10). "She was a difficult patient because she put up a wall. However, walls are meant to be broken, it just takes some time. Maybe at a future appointment, she and I will finally make that connection" (P20).

A number of essays discussed how cultural and linguistic differences complicate the patient encounter (30): "Unfortunately, with limitations to my Spanish-speaking abilities, I cannot fully express myself...I know what I would say in English but am unable to respond as I usually would" (P15); "The lack of control that came across seeing patients of different cultural backgrounds felt frustrating and sad" (P16). About a quarter of these concluded that such differences can be overcome (8): "The experience taught me that although I am limited in my language abilities, there are still ways in which you can show genuine concern and establish trust and a good rapport with your patients" (P21).

Twenty-eight students' reflections noted personal limitations and doubting their own efficacy: "I am only left with a sense of absolute uselessness in my inability to(sic) do much to ease his pain and suffering" (P48); "I cannot shake the doubt of the actual efficacy of my counsel" (P118). A small number of students ended their essays by expressing a negative judgment about the patient (11): "I found myself annoyed with the encounter...I thought it was extremely unfair that she was applying for worker's compensation for a problem that seemed so trivial" (P7). A slightly larger number of comments focused on negative self-judgment (14), in that the student felt he or she could have tried harder to reach the patient: "Was I the wrong healer that day? Did I wield my power like a bludgeon? Perhaps my own hubris stood in the way of my making progress that day" (P10). "I feel that with my attempts to gather information on the patient, I may have come off as probing and intrusive" (P86).

### Discussion

In many respects, the patients chosen by students to represent "difficult" encounters were typical of patients identified

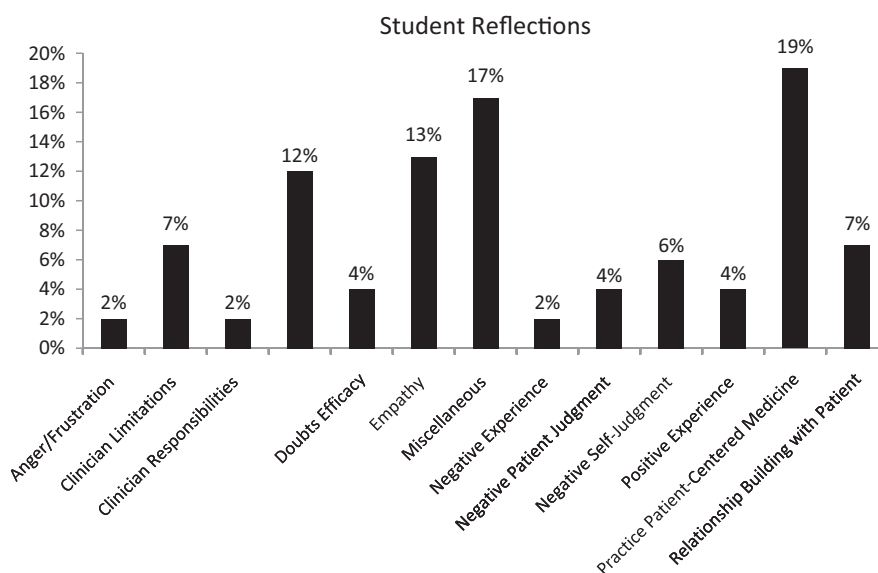


Figure 5. Student reflections.

as “difficult” in previous research in that many were older, often had chronic pain issues and multiple chronic diagnoses, and cultural and language differences. Older patients are often perceived by medical students as mildly frustrating or boring (Higashi et al. 2012). Students report especially difficult interactions with chronic pain patients (Corrigan et al. 2011). Lack of cultural competence can result in less than optimal patient encounters (Nazar et al. 2014). One-third of the patients described in this study (44) had mental health issues, often offered as an explanation of difficulty (Fiester 2012).

Other more complex explanations of perceived difficulty exist as well. Hill (2010) theorizes that physicians are most likely to render moral judgment against patients who do not legitimize the physician’s competence. In our investigation, students perceived difficulties when patients questioned or rejected the treatment plan, or when patients were discursive, telling stories or discussing family matters judged to be tangential or irrelevant to the student’s task. Such struggles over conflicting agendas (Shapiro et al. 2000; Lundberg 2014) may have undermined students’ sense of efficacy. Further, our analysis indicated that difficulty was often associated with acting out in patients and family members, such as yelling, withdrawing, resisting, or being insulting and uncooperative, behavior likely to generate feelings of helplessness and incompetence in the learner.

The introduction to clinical medicine – where so much is not predictable or controllable – often results in feelings of helplessness and loss of control in medical students. Consistent with this formulation, in these difficult encounters students generally portrayed themselves as overwhelmed, anxious, uncertain, and facing many predicaments. When they recorded shifts during the encounters in their own attitudes, they were as likely to be negative as positive. Students often took refuge in “standard” questions, statements, and behaviors, reverting to established protocol perhaps to regain control of the relationship.

Yet feelings of loss of control and rote behavior were not the whole picture. Students’ verbal and nonverbal behaviors also reflected significant efforts at empathy and connecting with the patient. A little over 40% of the total nonverbal actions they reported toward patients were empathic; a similar percentage of verbal behavior either expressed empathy or efforts at emotional connection. This contrasts favorably with one study (Weingarten et al. 2010) that found only 17% of videotaped encounters with experienced clinicians demonstrated physician empathy in situations of doctor–patient conflict. Although the encounters in our study were clearly stressful, students’ reflections emphasized the importance of patient-centeredness, perspective-taking, and relationship-building, similar to another study (Karnieli-Miller et al. 2010) of students’ reflections on stressful patient interactions.

There is considerable evidence that during their clinical years, students struggle in dealing with negative emotions in patients and in themselves. In one study, students reported avoiding empathic statements and felt uncomfortable addressing emotionally sensitive topics (Lumma-Sellenthin 2009). Another study concluded that skills used least often and least successfully were those that involved managing emotional aspects of patient interactions (Peters et al. 2011). Further, medical students’ ability to regulate

their own emotions and to develop empathic concern decreases over time, whereas personal distress in relation to emotions of others increases (Stratton et al. 2008). This body of research points to students being at risk during their clinical years for increasing emotional detachment and withdrawal. In fact, in our study, students did not seem too aware of their feelings, referring to their own emotional state on average only once in only half the essays.

Finally, students appeared to perceive themselves as fairly alone in these encounters. They mostly focused on their dyadic interaction with the patient. When they did write about the patient’s family, their observations were usually quite negative, tending to see family members as adversaries rather than allies. They also rarely mentioned their physician attendings. Although they acknowledged physicians’ patient-centered behavior, they also recorded negative remarks physicians shared with them about patients; and the majority of comments about preceptors were negative. A large literature demonstrates the critical importance of both positive and negative role models in influencing students’ professional identity formation (Stern & Papadakis 2006; Benbassat 2014), making it especially important to ensure that clerkship role models are available to help students manage and process difficult patient encounters.

### Limitations

Although theoretical saturation was achieved, this was a monocentric study in the context of a public medical school, which may have skewed the findings. Further, the study was based on students’ retrospective, self-reported recollections of events. These factors could have introduced egocentric or self-enhancement bias (Shepperd et al. 2008) as well as other memory biases (Hertel & Matthews 2011). Self-enhancement bias might have been particularly strong in the reflective component of essays, with students feeling they “should” draw a patient-centered or empathic conclusion. Mitigating these issues is that recollections usually occurred within days or weeks of when the event transpired. Further, students recalled not only general impressions but also specific verbal and nonverbal actions, which may have encouraged more accuracy in reporting.

### Conclusion

Third year medical students are at a liminal point in their training – not full-fledged physicians, but already far removed from laypeople. They are beginning to lay down tracks for how they understand all the “difficult” patients they will inevitably encounter in their future careers. In our investigation, they had already begun identifying “difficult” patients as those whose problems are not easily solvable and whose behavior challenged their sense of competence and efficacy. They often felt anxious, overwhelmed, uncertain, and puzzled as to how to proceed with such patients and lacked specific skills to do so. While trying to express empathy and establish emotional connection, they frequently relied on the history-taking and behavioral empathy protocols in efforts to re-establish control over interactions gone haywire. They also seemed to perceive that they received little guidance or support from their attendings

and noted instances of unprofessional remarks in interactions with these physicians. Nevertheless, in trying to extract lessons from these uncomfortable experiences, they focused on the value of patient-centered and relational approaches.

As no two difficult encounters are alike, an ability to work with uncertainty and complexity is critical. This requires reflective self-aware practitioners who can examine what they're doing (Epstein 2002; Haas et al. 2005). Students clearly have the capacity for such reflection, and it should be nurtured through such educational processes as Balint groups (Airagnes et al. 2014), reflective writing, and narrative medicine practices (Charon et al. 2015). Learning to respect the patient's alterity (otherness) is also critical (Warmington 2012). This may be especially pertinent with patients who have mental health issues, are "noncompliant", or have agendas that diverge from that of the student. Finally, cultivating emotional intelligence – the capacity to recognize and adapt to one's own and others' emotional states – can help temper, analyze, and de-escalate problematic interactions (Stratton et al. 2008; Riess 2010). In particular, it is important to help students transform reflection-on-action (retrospective reflection) into reflection-in-action (Schon 1987). Otherwise, their ability to reflect *post hoc* on what happened without having the skills to move this awareness into actual clinical encounters may result in increasing cynicism and burn-out (Billings et al. 2011).

## Disclosure statement

The authors report no conflicts of interest.

## Notes on contributors

**Johanna Shapiro**, Ph.D., is a professor of Family Medicine and Director of the Program in Medical Humanities & Arts at University of California Irvine School of Medicine. She has a longstanding interest in assessing the value of reflective practice in better understanding medical students' perspectives on their clinical experiences.

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**Adrienne Wong**, BA, received her BA from UC Irvine with a major in psychology and social behavior and a minor in public health. She plans on attending medical school and is currently enrolled in a pre-health post-baccalaureate program.

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