Alternative [redacted] Nurse Encounter

[redacted] Oh wonderful nurse, have you seen my water bottle and coffee cup anywhere?
Witchy Nurse: (sarcastically) Have you tried the trash?
Jennifer: What! You threw my stuff away?! (wisely thinks this only in her head, keeps her mouth shut)
Jennifer looks in the trash and finds her prized possessions.
After a good night's sleep, and a good breakfast, Jennifer reconsiders her initial idea of wringing Witchy Nurse's neck. She does decide to have a follow-up conversation with the nurse:

Jennifer: Thank you for the tip about the trash, dear nurse. Sure enough, that's where they were. That coffee cup is really precious to me. I would have been awfully sad to lose it.
Witchy Nurse: Didn't you notice the sign, "Clean up your mess"?
Jennifer: You know, I have seen that sign. I'm glad it's there, I hate a messy workplace, especially one we all share. I honestly didn't think my cups were "a mess."
Witchy Nurse: Well, I sure did, and I decided to clean them up for you.
Jennifer: Now I understand better. I admit I was really hurt when I saw my coffee cup in the trash. My best friend gave it to me and it has a lot of sentimental value. It hurt me that something I loved so much was treated as trash.
Witchy Nurse: (defensively) Well, it looked like trash to me.
Jennifer: Yeah, I understand that now. From my perspective, that was my beloved coffee cup. From your perspective my cups were a mess, and you saw yourself doing something – cleaning up the mess – that was really my responsibility.
Witchy Nurse: Exactly. You students always act as though we nurses are like your… servants.
Jennifer: Believe me, wonderful nurse, that is *not* how I think of you and certainly not how I want to treat you. It would mean a lot to me if next time you think I've made a mess, you just tell me personally, and I'll be glad to clean it up myself.
Witchy Nurse: (grudgingly) I could do that.
Jennifer: Would you like to hear the story behind this cup? It's really sweet.
Witchy Nurse (now slowly transforming into Nice Nurse): Sure…

Sweetness and light follow :-).

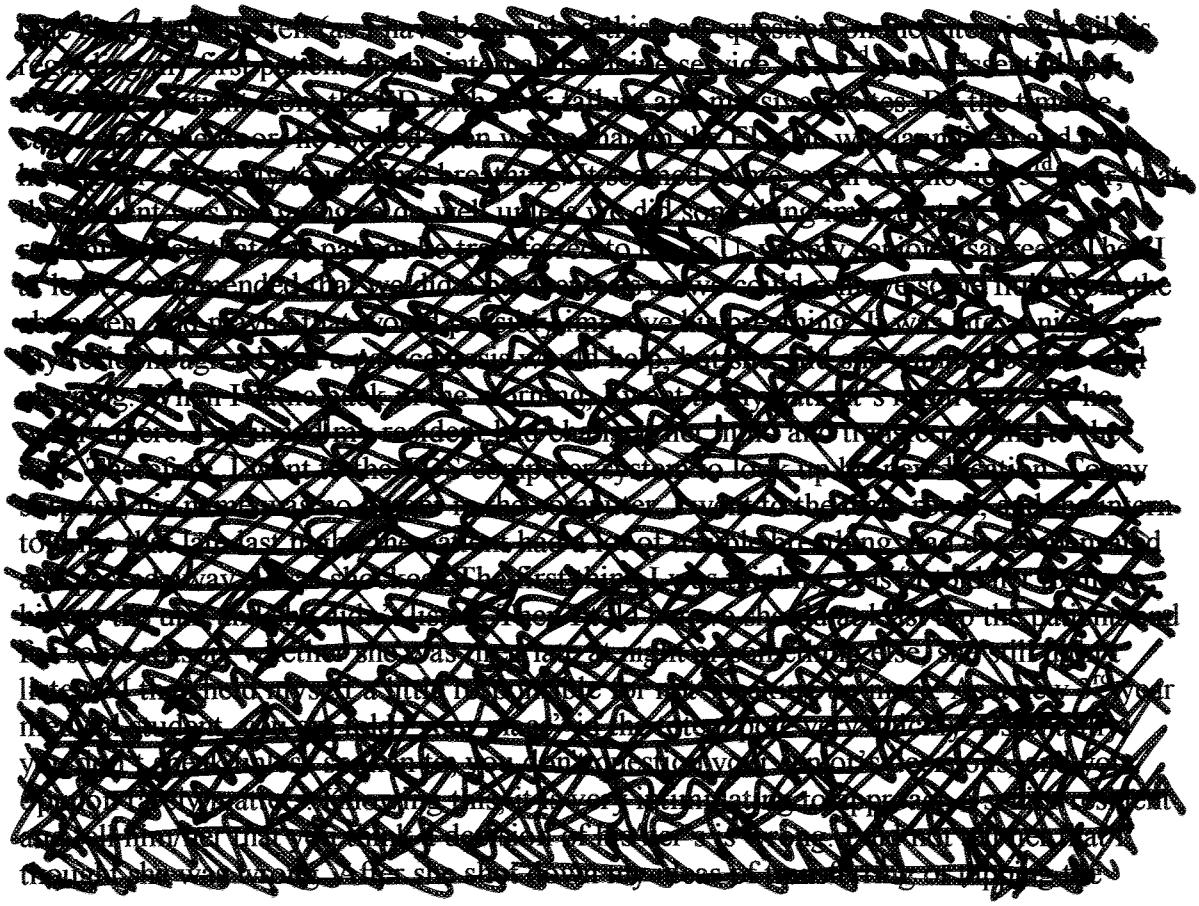
[redacted] AoD Assign #3

Hi [redacted] This is a wonderful story (except for the part where the patient died!) because of what you took away from it. It is such a hard thing to speak up in the medical hierarchy, especially as a wet-behind-the-ears 3rd year. But what you realized so well is that sometimes there is more at stake than an evaluation - sometimes it is someone's life. This does not mean you will always be right. Sometimes, when someone chooses a different path than yours, there are good reasons for this. But by speaking up, what you do is (respectfully) interrogate everyone's reasoning and decision-making. If sound, all to the good. If not, there's still time to take a different course. I think your essay also speaks to trusting yourself as a physician. As a new third year, your medical knowledge is limited, but it's not nonexistent. As you proceed up the food chain, it only grows. So trust it! Asking questions, offering opinions, exploring options should be viewed as rude or challenging, but rather as how a team works in the best interests of the patient. Good for you, and keep it up. I'm sure this story raised you high on the match lists of prospective residencies :-).
Best, Dr. Shapiro

From: [redacted]
Sent: Friday, February 19, 2010 2:00 PM
To: Shapiro, Johanna
Subject: RE: AoD assign 3

Pasted below is my assignment #3. Thank you so much,

[redacted]



[redacted] AoD Assign #3

Wow, [redacted], this sounds terrible - awfully chaotic and out-of-control. You title the essay, "Setting Limits," and you are right that certain guidelines need to be followed in the ICU. It also seems to me that you realize something else needed to occur, which might have made setting limits more moot - communication! Of course, this too is easier said than done, especially with such a large group of people (You have probably seen docs in similar situations try to identify a spokesperson for the group, a decision-maker. Sometimes this works well, other times it's like herding cats!). It sounds as though the family had not been able to get aboard a no-code status, despite the patient's pretty much hopeless prognosis. As you well know, this is often a very difficult step. Efforts may have been made to discuss this with the family, but perhaps the conversation just hadn't gotten as far as it needed to. Further, it sounds as though the family was not in any way prepared for the "process" of dying in the hospital. You make an excellent point that most people probably have very different expectations - and when they are violated, it can be a volatile situation. As I'm sure you understand, the death of a loved one (or sometimes not-so-loved one) can raise huge emotional reactions in family members; and it's well to be prepared for these. You are quite right in identifying the "nearness" of anger to grief. Yes indeed, limits are necessary to keep systems running; and sometimes there is too much baggage around a dying patient to sort everything out. But I think we could both agree that if the "death conversation" had happened sooner and had created space to address the family's concerns, you might not have had to call Security to help this family grieve appropriately! Thanks for sharing your thoughts, and I'm glad to hear everyone calmed down and could turn their attention to the task at hand - mourning the loss of this person. Take care [redacted] and get some sleep :-). Dr. Shapiro

From: [redacted]
Sent: Friday, February 19, 2010 1:58 PM
To: Shapiro, Johanna
Subject: RE: AoD assign 3

~~Dr. Shapiro,~~
~~So sorry about that. I've been focusing on nothing but sleep since starting my MICU rotation and kept forgetting to actually send the email.~~

~~Setting Limits~~

[redacted]

Hi, [redacted], thanks for the essay. The first thing I liked about it is that you chose an easily stereotyped population – the homeless – and sought out the individuality and uniqueness in each patient. When you think about all the challenges that life on the streets brings, it is doubly impressive that the first patient made such an effort. With your second patient, you are an acute observer of his deeper emotional issues and instability (pill or axe? hmmm). A patient like this puts physicians in a double bind, because he asks for help and then rejects it. You can offer suggestions, but he will just keep pulling the rug out from under… himself. You are not likely to get far with this person in a hospital setting (and your suggestion of counseling was certainly a good one); but you could always consider putting to use your excellent insight about his anger and potential self-loathing. "You seem pretty angry, Mr. X, and that anger seems to be getting in the way of you're doing what you need to get better. It seems like you've had a hard life. Can we talk about what's making you so angry?" or "You know, Mr. X, part of you wants to get better, because you keep asking us for help. But I've noticed you keep turning down our ideas. I'm wondering if there's a part of you that doesn't think you deserve to get better." You are absolutely right that, in the hospital setting, you probably are not going to be able to have an impact on his "readiness" to change. And unfortunately, this patient will likely NOT follow-up at FHC. But who knows, you might be able to plant a seed. Or not.

You know, [redacted], while in the profession of medicine you have many opportunities to help people who want help in a very straightforward relationship, you will also encounter situations where "helping" seems a lot more complicated than it should be. As you astutely comment, this is often because of psychological issues, emotional and social factors. It might help to think that everyone who goes to a doctor is asking for help, only sometimes they are asking in really distorted, destructive ways. You cannot help everybody; but you can always try; and then work to release the inevitable frustration and helplessness so with the next patient you can try again.

[redacted] ASSIGN. 3

Hi [redacted], thanks for your reflections aobut your drug-seeking patient. I thought you made several important points. One is the negative consequences of the pejorative labels that become attached to patients. The labels might be "correct" as far as they go (the patient may indeed be "drug-seeking") but they can be very reductive in the way they eliminate the patient's complexity and humanity (in other words, your patient may be a drug-seeker who also loves his family). The other point you made that I thought was important was the idea of the patient viewing you as the "enemy." In my view, we can't control how others see us except by how we behave toward them, so my focus might be on not *acting* like the patient's enemy (which can be harder than it seems, if the patient is demanding and angry and aggressive). Since I know you are a mom (and I was a mom once too!), I'd use this analogy. Sometimes we set limits on our kids not because we hate them but because we love them. You might not exactly "love" this patient, but you want to be clear that your actions emerge out of your best effort to determine what is in his best interest. You might not always be right (you might misjudge the functional vs. organic nature of his pain), but you are clean about your motivations as the patient's physician. And like our kids, the patient may not always like us, but hopefully somewhere in his heart he will recognize that we're on his side – NOT the enemy! :-) Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, February 02, 2010 11:53 PM
To: [redacted]
Subject: RE: AOD #2

Thank you for getting this in [redacted]a. I was thinking of writing you anyway regarding the final 5 minutes or so of class today (kind of like when you're leaving the exam room, hand on door knob, and the patient says, "Oh, and by the way, I have these chest pains..."). I hope you didn't hear me as saying that you "should" pursue an understanding of a patient's objection to receiving care based on gender, race, ethnicity, or some other characteristic. And you CERTAINLY have a right to protect yourself from the abuse of patients, both physical and emotional. All I was trying to suggest was that without engaging the individual, there is no chance that anything will change. Of course, as above, you don't have any special obligation to try to "change" anything (and, in the case of a true ideological racist, it's quite unlikely that you could do so anyway within the limited confines of the dr/pt relationship). But in the absence of engagement, the patient will just continue holding prejudices and stereotypical attitudes. As we discussed in class, SOMETIMES the patient may say something racist, but may be less a died-in-the-wool racist than someone who is ignorant and afraid. In such a situation, by engaging the patient ("Help me understand why you don't want me to take care of you")the assumptions and biases of the patient may be challenged, even upset. But please don't misunderstand me - I don't think you have any sort of moral responsibility to take on this extra burden. You have plenty to do being a doctor! :-). But I think it is reasonable to ask ourselves how we choose to position ourselves in relation to such a patient. Anyway, hope this sheds a little light...

Your insights below were very sensitive. I absolutely agree that compassion is hard to come by when the well is completely dry! A disciple once asked the Dalai Lama how to cultivate compassion. The Dalai Lama replied,"Start where it's easy to feel compassion." In other words, NOT when you're exhausted, sleep-deprived, hungry, and have an annoying patient. Start when you're well-rested and are gazing at a sick little innocent beautiful baby. The compassion comes naturally; and then you can gradually build on it. Unfortunately, as you observe, often in medicine you don't have this luxury of graduated cultivation. But even in its absence it is possible to pursue compassion, as you apparently do so well, through small mental and attitudinal adjustments.

In terms of the ER incident with the psychotic patient, I like the way you are able to see multiple perspectives - family members, attending, security personnel. And you learned (or relearned) a valuable lesson about the benefits of "just stepping away" from a volatile, rapidly escalating situation. Sometimes time does heal wounds! :-).

I hope you get a chance to rest those "tired student eyes" soon :-). Best, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Tuesday, February 02, 2010 7:02 PM
To: Shapiro, Johanna
Subject: FW: AOD #2

From: [redacted]
Sent: Tuesday, February 02, 2010 7:00 AM
To: [redacted]
Subject: RE: AOD

[redacted]

[redacted]
February 2, 2010

MANDATORY ASSIGNMENT #3: DESCRIBE IN NARRATIVE OR CREATIVE FORM ONE PARTICULARLY TROUBLING INCIDENT WITH A RESIDENT, ATTENDING, STAFF, PATIENT, FAMILY MEMBER; AND HOW YOU MIGHT HANDLE IT DIFFERENTLY NOW MAY BE ROLE-PLAY

Completed assignments must be submitted by email to both instructors – due prior to session 13

Comment [j1]: I SO understand this.

Comment [j2]: And I so understand this as well. As you say, the child is so terribly vulnerable, and the family members are behaving as "non"-caregivers.

Comment [j3]: [redacted] I think the question you're raising is what *is* the proper moral position you should assume toward the family (assuming they did perpetrate this crime)? Clearly, on a personal level, you have feelings of revulsion and anger (as do I). As a professional, you have put into place an (admittedly imperfect) process that at its best will uncover guilt or innocence; and if the former, will administer justice. In this context, what should your professional stance be? I'm not sure I know. I do know that I feel a great grief at the terrible perversion of caregiving that has resulted in devastating injury to this innocent child. My grief is primarily for the child, but it does encompass the perpetrators as well. It does *not* excuse them or in any way justify their behavior.

Comment [j4]: [redacted], I don't think this is unreasonable. But I wonder if you could hope for lifetime imprisonment with compassion rather than with anger? That is a question. I don't know, and I don't know if it makes a difference. But to me that is the question that needs to be sorted out.

Hi [redacted], thanks for sending along the assignment. I appreciate your wrestling with this one, and I appreciate your emotional honesty. I am always undone when I come up against child abuse and child molestation. These are actions that seem so contrary to basic human instincts that I can never find a resolution that satisfies me ethically or morally. Unfortunately, I did no better with your essay. All I can say is that I jumped in there with you as best I could, struggled alongside you, and came up empty-handed. I have to believe that there is something of value in asking the questions - even if they must be asked again and again. Thank you for not pulling any punches, and going straight to one of the most difficult ethical challenges imaginable. Best, Dr. Shapiro p.s. I also made some notes

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, February 02, 2010 11:30 PM
To: [redacted]
Subject: RE: AOD

Oh[redacted], what a great way to end the day. "Be Love" - I love it. It reminds me of the words of the great Sufi poet [redacted] - "Wherever you are, be the soul of that place." These aphorisms are easy to say and, as we discussed today, much harder to put into practice; but at least for me, they inspire me to aspire toward my better self! Thank you for sharing this. Best, Dr. Shapiro

Hi [redacted], thanks for being so prompt with this assignment. What a horrible experience! If you hadn't described it, I would never have believed something like that could happen. It was incredibly inappropriate, embarrassing, and completely unprofessional. It's hard to believe an attending could be so emotionally tone-deaf - plus completely irrelevant to the task at hand. In hindsight, I agree that something needed to be said to this physician. Of course, that is so difficult as a lowly medical student (who has to stand against the wall no less!). And especially when you might have felt somewhat abandonned by everyone else who observed this incident. Yet it was by no means a trivial event; and as you say, the only way this individual will ever learn about the effects of his behavior on others is by receiving some feedback.

AoD 2009-10 [redacted] Assign #3 Comment

[redacted], you address thoughtfully the perennial ethical dilemma of "when to speak up." (Niemoller's eloquent "I did not speak out" Holocaust poem). I think the answer to this question belongs to the individual; however, I also believe that most of us tend to err on the side of caution and safety (a few of us err on the other side, and could learn a bit more discretion). While all of us have a right to weigh risks and benefits, I suspect we often exaggerate the negative and minimize the positive. I'm glad this was a situation in which you raised your voice. Thankfully (!), your comments did not result in your failing the rotation, and hopefully illuminated the false premises of this supposedly objective presentation. I am confident that you will continue to speak out in multiple ways; and I am confident that the profession of medicine will be the better for it. Best of luck with the match, you have only good possibilities ahead :-) Dr. Shapiro

Hi [redacted], and thank you for an excellent assignment. Sadly, this is a dilemma (actually, the technical term is moral distress, because the morally correct action is not in doubt - as in a dilemma - but you are conflicted because this action might go against your personal best interests, i.e., upsetting an attending with possible evaluative repercussions) that many medical students here and elsewhere confront. In an ideal world, medical students wouldn't have to think about these things, because your attendings would always be modeling compassionate care. However, this is the real world, so you have stuff like this to write about! I appreciate that your intolerance for disrespectful behavior whether toward you or a patient has decreased this year. Thank goodness you've been able to resist "normalizing" pressures to accept rudeness or dismissiveness toward students and patients. A recent study found that among the medical students surveyed, although they frequently reported incidents of rudeness and disrespect toward patients, they rarely reported experiencing any emotional distress at these events. They had become "socialized" to perceive such events as normal or acceptable :-(. Continue to trust that "still small voice" :-). Just because a behavior is common doesn't make it right. Dr. Shapiro

-----Original Message-----

[redacted], this was an outstanding reflection. What a painful and stressful situation. I can easily understand why it went the way it did, and I am not sure the outcome would have been any different, no matter what you tried. However, in my view, you are very much on the right track in terms of your "do-over" thoughts. What struck me was how absolutely out-of-control this father felt (not all that surprising really). Since you couldn't give him a personality transplant, what you needed to do was figure out ways of respecting and empowering him - making him part of the team (all experiences he probably had as an engineer). It might just not have been possible - the gap might have been more like a gulf, considering the cultural and language barriers - but you might have been able to reduce the level of tension a bit. Thank you for sharing this with me. Dr. Shapiro

Comment [j6]: Yes, I think you've got it exactly. The rules that he knew, that gave him security, simply didn't apply in this situation (which involved the significant disability and perhaps death of his child).

Comment [j7]: I think this is very brave of you, considering the significant communication issues, but I think also you are on the right track (or the best possible track, which still might not have led to a better outcome).

Comment [j8]: This is really a good insight, Aaron. Again, this situation seems a lot about people's need for control – both the father's, but as you are honest enough to acknowledge, the team's as well. Of course, this in no way means you "accommodate" the father to the detriment of the child (after all, your patient), but sometimes we tend to give up too early. I wonder if an approach that somehow integrated the father's style of having expertise and useful ideas (obviously not putting him in charge of his son's treatment!!!), but finding a "role" for him on the team, instead of always being the critical voice outside the team, might have helped. Of course, this simply might not have been possible.

Comment [j9]: It sounds from this that you all were trying to find common ground, to look for approaches that could defuse and even win over the father.

Comment [j10]: I suspect this would be key to this individual. I get the sense of someone feeling terribly out of control, terribly helpless and "disempowered." Whether you could have actually achieved this is debatable, but this would have made a lot of sense as a goal.

Comment [j11]: It is very generous of you to frame things in this way. I think in peds, the most common error I see is that the parents become the enemy. Often understandable, but never the best outcome!

[redacted]

February 3, 2010

AoD Assignment 3: Troubling Incident

Hi [redacted] this was an excellent reflection. These are annoying incidents, but they are by no means uncommon; and once we are able to "calm down" a bit, they are valuable to help us explore other possibilities for responding to such situations in the future. I think you are quite right in identifying the emotions of fear and anger that arose for you when this resident responded with such vitriol. These are two of our most basic emotions, and lead on the

Comment [A1]: This does sound awful – I'd say a major overreaction and misinterpretation of the resident's part. What do you think she heard in your question?

Comment [A2]: Good for you for being aware of your feelings. Fear and anger are powerful emotions that can cause you to react in ways that only complicate the situation further.

Comment [A3]: We can only do what we can do at the moment. Perhaps it was fear that made you fall silent? By revisiting such difficult encounters, we can prepare ourselves to respond more closely to how we'd ideally want the next time around.

Comment [A4]: Good insight. A lot of times a difficult interaction is exacerbated by having an audience. People start to posture ("I must exert my authority" "I need to be careful not to look like a wimp")

Comment [A5]: I agree. This would merely have escalated an already tense encounter.

Comment [A6]: I'm not sure you needed to apologize for the question (unless you decided for some reason it actually was an inappropriate question. However, apologizing is almost always something that makes the other person feel better. So for example in this instance you might apologize for inadvertently upsetting the resident.

Comment [A7]: Outstanding, David. Most of us tend to avoid uncomfortable interpersonal situations. Unfortunately, that can be interpreted as adding insult to injury. Once your fear/anger have subsided, it's a great idea to revisit the situation with the individual, clarify your intent, and explore why she was so upset.

Comment [A8]: Absolutely. Finding out her perspective in no way ENDORSES that perspective, but simply sheds light on what's going on. As I intimated above, I suspect she felt you were trying to "get out of work." She was wrong, but until you know that, you can't address it very well.

Comment [A9]: That's a possibility too. As we've discussed, you want to strike a balance between being open to learning things about yourself and not taking others' behavior too personally.

Comment [A10]: Yes, I agree.

one hand to withdrawal (fear) and attack (anger). I believe our task as professionals (and people :-)) is to learn how to "thread the needle" between these two reactions, neither being too afraid to explore a situation further or so angry that we just want to prove the other person wrong. Of course, it is greatly complicated when power differential issues (such as between medical student and resident) are in play; but this is also pretty typical in life (in other words, it's rarely a purely "equal" relationship - you will either have more or less power than the person you're confronting), so it's worthwhile to explore different response options. Very good work, [redacted]
Hope all is going well, and please know I'm sending good thoughts in your direction :-). Dr. Shapiro

[redacted], this is a pervasive problem of course, and I don't know one physician who doesn't find this frustrating and distressing. I think you are quite perceptive to realize that "pain" is often not clear-cut. Pain can be both organic and functional; it can have started out organic, but become functional etc. Lots of combinations, none of them very appealing.

What is going on with these sarcastic, negative doctors (of whom I've seen many too!)? Of course, they are frustrated, helpless, often angry that they feel they're being manipulated (and often rightly so). Those feelings are perfectly understandable. So the question becomes, what is the "best" (i.e., most therapeutic, most professional) response in light of the contingencies of a maddeningly difficult situation? I'd assert that, no matter how understandable, sarcasm and negativity don't advance the wellbeing of either patient or doctor. You also make an excellent observation about how a misplaced, throw-away label (even the relatively benign [and sometimes completely accurate] of "drug-seeking") creates a whole constellation of expectations and attitudes, few of which are going to help establish a therapeutic relationship.

So what's to be done? As you indicate, there is no one right answer. Different practitioners do take different approaches - and some of the best try different approaches with different patients. Since this is such a complex situation, often the outcomes are not great. The sarcasm and negative judgment can probably go - what's left is good doctors trying to understand, trying to do the right thing for patients who may be addicts, may be in pain, and may be some of both. I really like your conclusions - these are all very wise, and in different degrees, I have seen these implemented by caring, skilled physicians in ways that maximize both effectiveness and concern. Very nicely stated. Best, Dr. Shapiro

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From: [redacted]]
Sent: Monday, February 08, 2010 1:26 PM
To: Shapiro, Johanna
Subject: Difficult Person Assignment

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, February 10, 2010 10:38 PM
To: [redacted]
Subject: RE: Assignment #3

[redacted] I did not find this "long" at all, rather completely engrossing. You were clearly willing to go the extra mile for your patient - how sad that instead of commending you, the resident responded first with dismissal, and then with anger. Fortunately, you did have an attending who also remembered that the patient's wellbeing should be the goal. And fortunately, the resident had enough awareness to realize he had behaved rudely and unprofessionally, and was able to apologize to you.

I really respect how much effort you put into extracting "lessons" from this experience (I hope the resident did the same!). You make excellent points about timing (I can imagine that "interrupting" the resident in the OR might have intensified his negative reaction); and the "public" nature of the exchange (when an issue arises in a situation with an "audience" [in this case the evaluative audience of an attending, as well presumably as others], it tends to exacerbate ego defense and protection). I also very much like what you say about taking an action on the pt's behalf. I didn't know this was possible for a third year, but it speaks to the importance of prioritizing the welfare of the patient above all.

[redacted], you learned some truly valuable lessons in "resident management" from this event. I'm sure your subsequent interactions with residents have gone more smoothly. I admire that you were able to review a painful situation (in which you were not in any significant way "in the wrong," but rather were simply advocating for your patient)and rather than focusing on what was "fair," or how badly you were treated (although you certainly were), you figured out constructive strategies for safeguarding people's fragile egos (not uncommon in medicine I'm afraid!) while not backing off on getting the best for your patients.

Thanks for sharing this incident. You truly made the most of it :-) Best, Dr. Shapiro

-----Original Message-----

Hi [redacted] Thanks for this assignment. You are quite right, the "role" of medical student figures prominently in these decision of how to handle challenging situations. You are often weighing what is in your immediate interest and what is in the pt's interest, as well as what is in the "offending party's" interest. It is a question of what has been termed "moral distress" - you know the right thing to do, but you are constrained by institutional and hierarchical factors. These are difficult situations to address, but certainly merit thinking about. Please see a few additional comments below. Best, Dr. Shapiro

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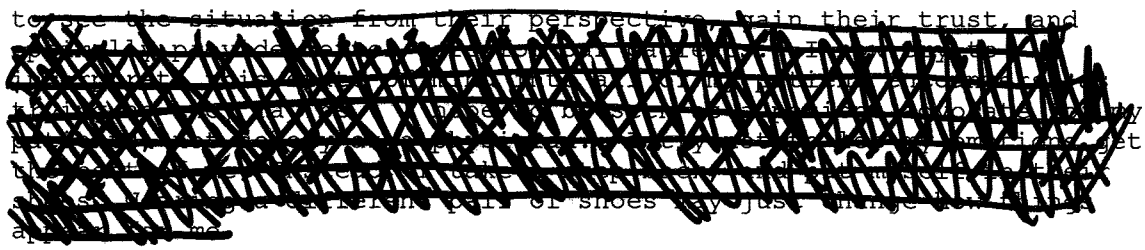
From: [redacted] **On Behalf Of** Kenton Fibel
Sent: Friday, February 05, 2010 3:35 PM
To: Shapiro, Johanna
Subject: AOD Assignment #3

DESCRIBE IN NARRATIVE OR CREATIVE FORM ONE PARTICULARLY TROUBLING INCIDENT WITH A RESIDENT, ATTENDING, STAFF, PATIENT, FAMILY MEMBER; AND HOW YOU MIGHT HANDLE IT DIFFERENTLY NOW MAY BE ROLE-PLAY



[redacted], thanks for the assignment. I really enjoyed reading it. I so respect the way you carefully noted your (very understandable!) initial feelings of being angry, wronged, and upset. There you were, only trying to help a very sick patient, and he ignores you and disrespects you! And then you take that crucial next step – you began to "think about and explore" your emotional reactions. You used your discomfort, not to "punish" or dismiss the patient, but to motivate understanding (searching the chart for some explanation or more information to explain the patient's puzzling behavior). Finally, you abandoned your very reasonable and appropriate (but totally ineffectual) strategy with the patient and experimented with a different approach. First, you backed away from the "power struggle" (hypertensive meds. vs. no hypertensive meds) and took a little detour to earn the patient's trust. Then you negotiated a compromise (again avoiding a win-lose situation). Wow, this is a perfect example of how to constructively work with difficult emotions in ways that actually turn them to the patient's benefit. I also liked what you said about not being dominated by your initial negative emotions, but rather becoming interested in the patient's response, then interested in the *patient*, thus cultivating empathy and connection. So well done, [redacted]. Thank you for sharing this incident. It makes me very happy that you are going to be a physician :-). Best, Dr. Shapiro