Hi everybody. I just wanted to say how happy it made me to spend Tuesday afternoon back in the Art of Doctoring. You're a great bunch of people, and it was a pleasure to listen to your insights, opinions, emotions, and humor. It occurred to me that although the focus of our discussion very appropriately was the powerlessness of being a medical student, it's important to be aware of how pervasive this feeling is in the world of medicine. Patients of course spend a good deal of time feeling powerless. The physician and medical philosopher Eric Cassell identified the overriding experience of illness as a loss of control, and that includes potentially loss of one's identity, loss of meaning, loss of role functions, loss of autonomy etc. Full-fledged physicians often experience helplessness as well – because their patients won't do what they say; because the health care system prevents them from caring for patients as they'd like; because they can't save the lives of patients they care about; and because sometimes they despise patients for whom they know they should care. I won't even comment on the helplessness experienced on a daily basis by "ancillary staff," as we so conveniently group them, often people required to work long, hard hours at demanding jobs for insufficient recompense. It is to be hoped that by becoming more familiar with the triggers and attributes of helplessness in yourselves, you will also become better able at recognizing it in others, and better prepared to extend an empathic hand to them in their lostness and despair.

Happy Thanksgiving to you all. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Wednesday, November 24, 2004 3:44 PM
To: [redacted]
Shapiro, Johanna
Subject: RE: Art of doctoring

Here are the notes from yesterday's session. The assignment for next Tuesday is at the end.
Happy Thanksgiving everyone.
- [redacted]

Art of Doctoring -- Session 4
11/23/04

"Powerlessness"

The session opened with invitations of our thoughts and feelings evoked by the word "powerlessness."

Responses included –

1. learned helplessness
2. lack of control (med students on average probably have a higher need to feel in control)
3. frustration
4. depression
5. anger

6. freedom
7. surrender/acceptance without fighting back
8. resignation
9. it depends on one's perspective and definition of "power"

Q: Can any of the above feelings be unhealthy?
Responses –

10. yes, if it impacts other situations/has a global effect
11. The feelings themselves are neither good nor bad. It is one's *response* to the feelings that may be healthy or unhealthy (although we may have tendencies to label the feelings as good or bad b/c of the discomfort they cause).

We were then encouraged to describe and discuss specific situations that engendered feelings of powerlessness.

Situation 1: Getting discounted as a medical student in a patient encounter by –

- a resident interrupting and taking over an interview
- getting cut off by residents/attendings during a presentation/history taking
- not being informed of changes in patient status by the rest of the team
- surgery… nuf said

Q: What are some of our ways of responding and dealing with feelings of powerlessness?
Responses –

- be polite to the individual, b/c he/she will be evaluating you, but hold a grudge against him/her or hope to never have to deal with the individual again in the future
- Treat the situation as a learning experience and remember to never discount others in a similar fashion in the future. Choose to avoid being a source of pain to others when you become the person in power. (ie turn the situation around to gain a positive sense of control/future empowerment)

12. Q: What are some ways to help one feel empowered in the present?
    Responses –
    - engage self with team/superiors and be proactive
13. - express your feelings directly to the individual…but, can we control another's response and feelings? How receptive will the person be to your comments? Is it realistic to expect that people will change? What is the *Desired Outcome* from choosing to bring up your feelings with the individual?
    - an individual's perspective drives the desired outcome
    - how did you interpret the situation? Did you take things too personally?
    - try to see the situation from the other person's perspective – don't blame the person, but try to understand where he is coming from…maybe he is having a shitty day

- instead of confronting or criticizing the other person, approach the person and be honest and share your feelings with him. Tell him how you feel and see if he can help solve your problem or propose a solution

...comes down to the "art of negotiation"

Q: is there time to "express your feelings" in a clinical setting?

14. choose your battles; how important is the situation to you
15. vent to friends/family/course director/write in a journal etc... but remember not to minimize your own feelings (analogy of med student as steam kettle on top of a fire...if you don't release some steam, you will eventually blow)
16. Serenity Prayer:

God grant me the serenity
to accept the things I cannot change;
courage to change the things I can;
and wisdom to know the difference.

Situation 2: Observing a superior/ancillary staff/colleague mistreating a patient.
Q: Can you change other people?
Responses –

17. ask the superior directly why he is doing what he is doing. Maybe there is a reason for his actions that you don't understand.
18. Try to make the person aware of his actions/"problem"
19. - Try to recoup damage done by directly speaking with patient
20. Is there a problem with our assumptions about the hierarchical culture-of-medicine where unpleasant situations with superiors may be ignored without question

Assignment for next class on 11/30:
Be observant about situations that may make you feel powerless. Write a paragraph describing and analyzing the situation and describe your response/approach to dealing with the situation. We will pick a few selections to be read and discussed next session.

(note: the topic for this session was inspired by multiple discussions in this class, last year, by students who felt frustrated, discounted, and powerless to change situations they encountered in the hospital)

AoD COMMENTS 12/04

[redacted], your essay was a thoughtful, outside-the-box approach to an initially frustrating and helplessness-inducing situation. I liked several things about your approach: 1) Although you initially defined this situation in oppositional terms ("your" vs. "her" perceptions of your role and obligations, "upon deeper analysis" you discovered additional ways of thinking about your circumstances. In particular, you realized you could be more flexible in how you defined optimal learning for yourself. 2) You tried several different strategies, including reflecting on your own expectations, contacting the course director, and planning to approach the preceptor directly, without becoming discouraged that none of them would likely yield a "perfect" solution. 3) You shifted your thinking about the relationship as a "top-down" one between a controlling preceptor and a powerless medical student to a more mutual one which would involve a collaborative effort. 4) You paid attention to the "style" of your preceptor, including limitations, but also her strengths, and thought creatively about how you could work with her style to best advantage. 5) You generalized from this particular situation to the awareness that each encounter with a preceptor over the year will be characterized by somewhat different dynamics. Some of these relationships will flow smoothly and effortlessly, because expectations, priorities, and values will be in sync. Some will be frustrating, as the one you describe. But if you realize that negotiation within a given relationship is more the norm than the exception, you won't take the frustrations so personally, and you'll also feel more empowered to work toward positive change. I am impressed with your creative approach to problem-solving and your persistence. I hope you are rewarded with a positive outcome! Regards, Dr. Shapiro

[redacted] I hope we have the opportunity to further discuss the kind of situation your essay presents. Not that there are any answers, no magical solutions lying under a bush. But it does make me think of a couple of things. One is that committed physicians do develop knowledge and skills over time that take best advantage of our very flawed healthcare system. They learn where to get the cheapest diagnostic tests, who are the specialists in the community that sometimes donate their services, how to get emergency coverage etc. That having been said, a huge gap often exists between what should be done and what can be done. This is a source of terrible powerlessness for which there is no really good answer. We *should* feel helpless, and we *should* feel the injustice. When we are able to just shrug it off, we know we have lost something essential to making us human. Even worse, I sometimes see physicians who attack the patient as an antidote to their own helplessness: "You shouldn't be here illegally"; "You shouldn't be working under the table" etc. This adds shame and blame to the patient's already terrible circumstances. Somehow we have to be able to accept that we cannot always make things right for others, never in a complacent way, but in a realistic sense. I personally think it is helpful in these situations to ask forgiveness from the patient, either literally or in the imagination. In the end, it comes down to what [redacted] said in class: can you look at yourself in the mirror and say, I did the best I could for this patient. That is sometimes

not what should be, but sometimes it has to be enough. Thank you for reflecting so poignantly on this dilemma. Dr. Shapiro

[redacted]

Hi [redacted]. You describe an interesting learning situation. Perhaps I'm missing some of the nuances because we did not discuss it in class, but it seems to me that this is an example of how learning occurs between more junior people (you *and* the senior) and a more seasoned clinician. Without more details, several interpretations are possible. For example, you and your senior might have been too quick to discharge the patient, while the attending favored a more cautious approach. Alternatively, the attending might have been overly vigilant, and your plan might have been perfectly appropriate. To me, this simply seems like an important clinical issue for discussion, where the best argument carries the day. What interested me was why the attending felt s/he had to be "a little sharp," with the implication that you weren't taking the patient's symptoms seriously enough. This innuendo is the kind of thing that inevitably detracts from a positive learning environment. The attending could have made all of his/her points without impugning your dedication in any way. Nevertheless, your solutions are good ones: 1) You decided you didn't need to personalize the issue, and also decided it was not a sign of any underlying problems between you and the resident: therefore you could let it go 2) You also decided to consult with a somewhat wider group, in order to ensure that you had considered as many options as possible. These two strategies should result in your not feeling personally attacked and in feeling better prepared in similar situations. Very carefully thought-through. Thanks for sharing, Dr. Shapiro

[redacted]

[redacted], thanks for sending in your patient example of powerlessness. It was an excellent one, and Dr. [redacted] used it as the initial prompt to stimulate discussion. You will probably not be surprised to hear that your fellow students identified with this situation and agreed it was both common and frustrating. Patients frequently are insufficiently motivated, even noncompliant, lack family support, and don't have adequate insurance coverage. For a constellation of reasons, you cannot provide the kind of care you know is theoretically possible. As a result, you know that your patient is at greater risk. You wonder if "doing the best you can" is enough. I think these are all signs of a conscientious and committed physician who doesn't want to be complacent and doesn't want to take the easy way out. The only risk I have seen on occasion with this attitude is that our helplessness and frustration are transformed into anger and blame toward the patient, always a convenient outlet for our own projective fantasies. "If only she would try harder..." "Why should I care if she doesn't..." etc. These are understandable reactions, but are really just ways of distancing from powerlessness. It is probably better to acknowledge the helplessness from a place of loving-kindness toward the patient and toward yourself. Then I think you will do your utmost (which often will still fall short through no fault of your own) without emotionally abandoning the patient. This is a very core issue in medicine, and I'm very glad you brought it to our attention. Regards, Dr. Shapiro

[redacted]

[redacted] the situation you describe is painful to read about. Unfortunately, as you probably have learned as a fourth year, it is not uncommon; in fact, in one form or another, it happens all the time. I admire that as a "lowly" third year, you stood up for your patient. How crushing it must have been to learn that the bottom line was the department's budget. Yet it is impossible to blame the radiology department because they in turn are under tremendous pressure from the institution; and the institution itself is forced to function within a highly flawed healthcare system. Compounding the problem was the patient's lack of understanding of the gravity of her situation. Even though a partial solution (outpatient MRI) was offered, it sounded as though it was not guaranteed, and would be in conflict with the patient's priority to return to Mexico and see her children. There are no perfect solutions to this dilemma, and each individual must ask him or herself how much of the burden s/he is willing/able to shoulder. You did a lot – you advocated for the patient with the radiology department, you found a possible approach that might not have been offered to the patient if you hadn't questioned the initial decision not to perform the MRI, and you tried to convey to the patient the potential seriousness of her symptoms. Was that enough? Only you can say. But regardless of how you answer, don't minimize these efforts. Of course it is always preferable when the outcome is positive – patient stays, gets the MRI, is properly diagnosed and treated, her life is saved, and she lives happily ever after with her two kids. However, in my value system, not only the outcome but the effort is important. You acted with compassion and integrity – that has to matter too. Thanks for sharing, Dr. Shapiro

[redacted]

[redacted], I was intrigued by your speculations about whether experienced clinicians ever experience helplessness. And I would agree that, although all people experience the whole gamut of emotions, I'd guess that the dominating emotion of an outstanding clinician would rarely be helplessness – perhaps grief, or sadness. As you say, helplessness comes when you feel you can't do anything, and even in a situation of terminal illness, the wise physician realizes s/he still has a great deal to offer the patient. Your example of the pcp who perhaps made an error in judgment, or at least a wrong call, is an interesting one. In this case, she still had a chance to "reverse" the effects of her decision, so she might not have felt hopeless. If the patient had died due to this medication, then hopelessness, self-blame, and guilt might have arisen in the pcp. Medicine is a challenging profession in that respect because sometimes your decisions really do have life and death implications. That is why it is so important to incorporate some room for error, some sense of personal fallibility into your self-image. This by no means implies being complacent about medical mistakes, but does recognize that, despite trying to do your best, over the course of your career you may inadvertently do harm to another. However, I think if you can admit this possibility, when it happens your feelings will not be primarily hopelessness, but humbleness and a determination to learn from your mistake. Thanks for sharing, Dr. Shapiro

[redacted]

You describe a terrible, but sadly not uncommon, situation in the America of the 21st century. What a tragedy and what a disgrace. At Santa Ana I have seen uninsured patients who likely were having a heart attack refuse to go to the ER because they didn't know

how they would pay the bill. Such events make me feel not only helpless but angry. It is a crazy system that says when we could really help someone, and easily too, we can't, but when we can only snatch him from the jaws of death to leave him a helpless cripple, we can give it a whirl! In terms of assertive actions, this is a good reason to work in support of universal healthcare, or some method of healthcare delivery that you consider more just than our current mess of 40 million uninsured. I'd say the major risk to the doctor-patient relationship in such an awful context is either deflecting anger onto the patient or emotional abandonment, and I have see both happen. We need to remember that this is not the patient's fault (even patients here illegally, and therefore not "deserving" of health care in some eyes, are driven by large economic forces that our own country in part feeds) and that, although his presence reminds us of our own and our country's shortcomings, he deserves help. At the least, we owe this patient continuity care, and our commitment that we will keep looking for a crack in the system that will allow him to slip through (when I was over at the Anaheim clinic, I was impressed by how often the dedicated physicians did find cracks to slip their patients through!). Thanks for sharing this very difficult situation in class. It obviously sparked lots of recognition. Regards, Dr. Shapiro

[redacted]

Hi [redacted]. You presented a really challenging quandary. I think hands down drug-seeking patients are the bane of the ER – and often the primary care – doctor's existence. What makes management of such patients so difficulty is that in most cases, relationship issues are trumped by desire/need for the drug of choice. Their personal relationships are usually in shambles, and it is really hard to develop a meaningful doctor-patient relationship, which would be the foundation on which you'd want to build in negotiating a course of intervention and abstinence. As we discussed in class, in addition to the inherent frustrations and sadness of an addicted patient ("wasted life" etc.), you became caught up in a web of dishonesty and dissembling – on the patient's part, on the friend's part, on the attending's part, and ultimately on your own part. One possibility is to try, against the odds, to establish relationship while setting limits. This involves expressing sincere care ("I believe you're in a lot of pain") but rejecting the easy way out (that also supports the patient's habit) ("Although you are asking for Demerol, this is probably not the best way to manage your problem"), and confronting deceptions ("Look, if I'm going to be your doctor, we have to be straight with each other. Let's talk about drug use and why you're in the halfway house"). But for a medical student to initiate such a conversation in the ER is not realistic without the support of an attending or at least a resident. So you have to decide where to draw your personal line. Will you question the attending's approach? Will you tell the patient that he should think about ways of managing pain that don't involve narcotics? These are hard questions to answer because there is a low likelihood of successful outcomes with either of these strategies, and high likelihood of annoying the attending and irritating the patient. In this case, you must do whatever adequately balances your sense of personal integrity against the perceived futility of taking a stand. I hope we have a chance to discuss this further, although as you can see there are no "perfect" answers, no really satisfying solutions. Thanks for bringing this one to our attention, Dr, Shapiro

[redacted] the situation you describe is really a tough one. I agree with you completely that what makes it so hard is the unequal power relationships. People with lots of power (and perhaps some of it directly over you) come at you with inquiries in direct violation of HIPPA. It is not unlikely that they choose you precisely because you are low down on the medical totem pole, and are perceived as most vulnerable to pressure. This is unethical behavior on the part of these individuals, especially in the aftermath of your explaining the grounds for your refusal. Clearly anyone would feel frustrated and angry in these circumstances. It was a very good idea to discuss this problem with your team, so that a consistent policy can be established regarding inquiries of friends and co-workers. You've clearly made the appropriate ethical and legal decision not to discuss the patient's situation with anyone except family.

That having been said, I'm interested in the point of view of these people, particularly the attendings. For example, what motivates them to continue asking? I imagine that some of these inquiries might be motivated by physician arrogance. These are people used to being "in the know," and used to having others (especially subordinates) respond quickly and positively when told to do something. There may be other reasons as well. They may feel helpless and out of control at the predicament of a valued coworker, and they choose their default mode of mitigating these negative emotions, i.e., gathering information. Perhaps they have deeply caring feelings for the patient and the only way they can express these is indirectly, through asking about her medical status.

Who knows? It might be possible to have a conversation with the attendings sharing both your own dilemma and their dilemma: "I can see how concerned you are about Mrs. X. As we've talked about, I really can't answer questions of a medical nature about her condition. But she's lucky to have someone who cares so much about her, and wants to help her. Even though she's in a coma [if this is something you could disclose], it might help to go to her bedside and hold her hand for a few minutes." Of course, this kind of dialogue is much easier when there are not unequal power dynamics.

In any case, this is a situation with multiple conflicts and one I hope we get a chance to discuss at greater length. Thanks for sharing this, Dr. Shapiro

[redacted] what a great example! When I first started working in medicine, I too was astonished at how ignorant people seemed to be about their chronic illnesses, past surgeries, personal medical history. I too tended to blame the patient. But after having observed literally thousands of doctor-patient interactions, I've concluded that communication on these topics is simply not a straightforward or easy process. Doctors *do* consent, provide explanations, give information, and ask "Do you understand? Do you have any questions?" Patients *do* listen, nod their heads, and say yes they understand, and no, they don't have any questions. As you point out, often the physician does not appear approachable. The patient does not wish to challenge the physician's authority or knowledge by asking questions. The patient also does not wish to look stupid! The patient may also hold the culturally-influenced belief that disease and its cure is the

physician's responsibility. The patient may be struggling with language limitations both in hearing what is often a rather complex didactic presentation on the part of the physician; and in formulating clarifying questions. On a psychological level, part of the patient may not want to think about this problem, may not even want to accept that s/he has a serious medical condition. On top of all this, the doctor is in a hurry, and wants to move on. Rarely do we take the time to verify that the patient *really* understands, as opposed to saying s/he understands. This is a hugely pervasive problem in medicine, and it is by no means restricted to patients with limited education or from other cultures. I really thank you for paying attention to this issue, and hopefully we can discuss it further in class. Thanks, [redacted], Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna

Sent: Wednesday, February 25, 2004 4:54 PM

To: [redacted]

Subject: art of doctoring essay

[redacted], thank you so much for sharing this work. I'm impressed with how seriously you took this assignment, and the obvious care and thoughtful honesty you put into it. I think your assessment of the medical school environment shows evidence of acute observation, and unfortunately I couldn't agree more with your conclusions. Although I know none of this is really humorous, I did have to smile at your comments equating being seen with being perceived as in the way – too often, how true!

Your suggestions for changing the system are quite excellent, and made me particularly glad that you'd given a copy of this to Dr. [redacted], who is in a better position to change the system than I am. The idea of a teaching session for residents is outstanding. I don't know if you were aware of the BEST program that Dr. [redacted] ran the last three years, but it actually did something quite similar to what you propose. Dr. [redacted] worked with (a select number of) IM and FM residents on a set of teaching skills, including how they interacted with medical students. Although this program is essentially in abeyance at the moment (because it ran out of funding – another systemic problem!), with your permission I'd like to pass along your suggestions to Dr. [redacted] for possible incorporation when she is able to revive this program. Your point about involving attendings in an oversight capacity is also extremely well-taken.

I appreciated your honesty about struggling with what you can do personally about these problems. In a way, it's not fair to ask you (or any student) to do personal work when none of this is your fault, it's a systems problem. I do see this, agree with your analysis, and fully support any program, any intervention, any anything that can positively influence resident and attending behavior. My only point in asking you all to think about what you can do personally is to a) reduce the feelings of helplessness, by focusing on a domain that is more under your control than the actions and attitudes of others b) help you develop the skills to cope when you find yourself in a bad situation, so that no matter how others behave, you know that you are hanging on to your own integrity and values. My personal belief is that by doing so, you are less likely to morph into one of those thoughtless, exploitive residents! In fact, you came up with some wonderful ideas, which I think will make your learning experience more enjoyable and make you "visible" (at least to yourself) in a way you can feel proud about.

Finally, underneath the problem-solving, I hear your pain and frustration at having to pursue what is probably a lifelong dream (ie., becoming a physician) in such an inhumane, judgmental, harsh environment. It is with an eye toward reducing this suffering – and the suffering of your fellow students, because I think your feelings are widespread – that I'm encouraging you to develop personal strategies for handling these difficulties in a way that empowers you and helps you grow as a person.

Thanks again [redacted]. It does get better, I promise you that. Dr. Shapiro

[redacted], this looks excellent. Nice work. You've done a great job here by

1) operationalizing a concept (judgmentalness) into a specific observable behavior (language use). You could even take this a step further by reflecting on judgmental language that you've heard yourself (or others) use that you'd like to avoid (do less of); and identifying, as you suggest, specific ways in which you can shape positive feelings in yourself (and perhaps your listeners) by including one kind, admiring, appreciative, caring etc. comment about the patient

2) defining two specific situations in which you're going to monitor/intervene with this behavior (formal and informal settings). I really like that you are tackling the "informal" part - it's much easier not to use "right speech" in this context!

3) formulating specific interventions that might affect the target behavior. You might consider "experimenting" by trying each of these ideas for a few days, and see what effect it has; you could also try combining a few of these ideas, and see if you can maximize or increase the "effect size."

Please try to write down on a daily basis a few notes about what you did, what effect if any it had on your language, and whether your noticed any effect on your two larger outcomes (decision-making and feelings of decreased resentment/increased happiness (! - I like it!).

Thank you for taking this assignment seriously. I hope you'll find it a valuable exercise. Regards, Dr. Shapiro

-----Original Message-----
[redacted]
Sent: Tuesday, March 09, 2004 8:05 PM
To: Shapiro, Johanna; [redacted]
Subject: RE: personal projects

Hi there,

[redacted]

Thanks,
[redacted]

[redacted], I think you've hit on a really important insight, one it took me a lot longer to discover. A happy doctor does make for happy patients. So it's really important to choose work that excites you, pleases you, challenges you, and is meaningful to you (at least PART of the time!).

I hope you will speak up as you're comfortable. I know you are a little shy, but whenever you do speak out, what you have to say really contributes something thoughtful and valuable to all of us. So give it a whirl!

Apropos of our mutually harried meeting, here is a story you might enjoy:

A student of Buddhism traveled for many days for an audience with a wise teacher. When he finally arrived at the temple, he approached the roshi's study and asked to be admitted. The assistant turned him away, saying the roshi was not in. But when the student walked past the door, which was open a crack, he peeked in and saw the roshi meditating. The next day he returned, but the same thing happened. Same on the third day. Finally, on the fourth day, the assistant motioned him into the room.

"Thank you for seeing me, master," said the student to the roshi, "but I've been trying to see you for four days. Every day your assistant told me you weren't in, but when I walked by your room, I could clearly see you sitting here. Why did the assistant tell me lies?"

The roshi smiled. "My assistant told the truth. To my great regret, the wise teacher you wanted wasn't here until today."

Sometimes, despite our best intentions and efforts, the person we want to be is somewhere else! But I did have a good trip :-).

-----Original Message-----
From: [redacted]
Sent: Wednesday, February 04, 2004 8:30 PM
To: Shapiro, Johanna
Subject: RE: thank you

[redacted]

Dr. Shapiro,

[redacted]

Thanks again for your insight and support.

Haidy

Shapiro, Johanna

From: Johanna F. SHAPIRO [JFSHAPIR@uci.edu]
Sent: Wednesday, February 04, 2004 4:53 PM
To: [redacted]
Cc: 'jfshapir@uci.edu'
Subject: art of doctoring assignment

Hi [redacted]. I'm so glad you shared your "beauty tips." Audrey Hepburn remains one of my favorite actresses - and one of my favorite people who ended up doing some real good in the world. She typified both outer and inner beauty. I especially like the injunction, "Never throw out anybody." Amen to that! It makes me think of all the times when, metaphorically at least, we "throw out" someone by ignoring them, disrespecting them, patronizing them, blaming and shaming them. I also think she is very wise in recognizing that helping others is related to helping oneself. It is not an either-or dichotomy, but rather a both-and unity. What a great lady! Thanks for sharing. Dr. Shapiro

9/13/04

Dear [redacted],
Thank you for writing about this incident and for sharing it with me. Wow! It sounds like you were treated very unfairly, with no attempt at empathy, and instead a lot of blaming and shaming. No wonder you felt angry and upset! You were also concerned about how these incidents would affect your peds evaluation. It's not at all surprising that all these feelings came up. It sounds like you were sick and exhausted, pushed to your edge, and instead of encountering understanding and help, you were criticized and punished. This encounter embodies the *worst* of medical education.

You made a comment that you're not sure how it could have been handled differently. It might be more accurate to say, there might have been some other choices, but even if you'd said or done something different, it might not have affected the end result. That's true. We can't change other people's behavior, we can only try to open up different paths, and see if they'll begin to walk down them.

So, was it understandable you were upset and angry? Yes. Did you "deserve" to feel this way because you were being treated unfairly? Again, yes. But did these feelings improve the situation at all? Probably not. Did they hurt the mean resident? Maybe a little, but maybe not. Did they hurt you? Here I think the answer is yes again, because you are still wrestling with this 2 ½ months after it occurred. So one goal would be to help the mean resident to start "walking down a path" of kindness and compassion, but another goal would be to reduce your own "unnecessary" suffering (by that I mean that some suffering is "necessary": when you're sick, you feel miserable, and you can't change that much. But on top of being sick, if you start to feel angry, upset, defensive, helpless, scared, then you've just added some "unnecessary" suffering to what you already had to endure.

Maybe there are some different ways the scenario could have played out. First, it might not hurt to try that "Algorithm for Challenging Situations," since this certainly sounds like a challenging situation. So here's how things might proceed...(collapsed version, for the sake of simplicity!).
SICK ELENA (SE); Hi, Mean Resident.
MEAN RESIDENT (MR): (Grunts; doesn't answer)
SE: Is something wrong?
MR: Yes. You were late this morning, plus you didn't show up at all yesterday.
SICK ELENA (SE): (Takes a breath; quickly thinks to herself, "I'm thankful I have a resident to teach me, even if she does it in a rather mean way. My intention is to really hear the resident's point of view, to share my own perspective, and see if we can't resolve this situation. And I resolve to try to use only right speech, even if the resident doesn't do the same." Then decide whether you're going to address this situation, or let it go. If you decide to address it, things might go like this).
MR: Why aren't you saying anything?
SE: Sorry, I was thinking about what you said. MR, it sounds like you have two concerns about me. I was late this morning and I didn't come in yesterday. Is there anything else I missed?
MR: No, but that's more than enough!
SE: And you seem really upset about both of these incidents.

MR: You bet I'm upset.
SE: Could we talk a minute about them?
MR: Fine. But hurry up, we have patients to see.
SE: (At this point, you have to look honestly at the criticism and see whether it has any merit. Try to do so nondefensively – is there anything you can learn from this input? Depending on what you decide, you might answer like this:) As far as being late is concerned, I agree with you that, as doctors, we should try really hard not to be late. I sincerely apologize for causing inconvenience to you and the rest of the team. Just by way of explanation, not as an excuse, I ran into some unexpected road construction this morning, and as a result I didn't get here till 7:05. But tomorrow, I'll make allowances for this, and arrive on time. Thank you for pointing this out.
MR: (caught off-guard by the apology) Oh… you're welcome.
SE: Thank you. In terms of yesterday, I can certainly see how shocked and disappointed you'd be if I just didn't show up when you expected me to be there.
MR: That was *exactly* how I felt!
SE: You were counting on me and I let you down.
MR: Right.
SE: No wonder you were upset! Can I share with you what happened from my point of view? (MR nods) I've been really sick for the last week. I thought that because it was Veterans' Day yesterday, it was a scheduled day off, and it would be a perfect time for me to stay home and try to recover. Did I misunderstand? Was I supposed to come in according to the schedule?
MR: (a little confused) Well, you don't *have* to come in, but I did kind of expect it, since a couple of months ago a student *did* come in on *her* day off.
SE: Oh, I didn't know that. Did you tell me about that?
MR: No, I didn't. I thought it you were really dedicated, you'd show up.
SE: I really appreciate your sharing both that event and your expectation with me now. I had a different understanding, but now that you've clarified for me, I'll be sure to talk with you if I'm feeling so sick I'm worried I can't work or if the schedule shows I shouldn't be here, so we can problem-solve together and avoid any more miscommunications. How would that sound?
MR: (Begrudgingly) That would probably work.
SE: (Friendly) Good. Now could I ask you a favor?
MR: Omigod! You *cannot* go home just because you're coughing a bit.
SE: No, no, that's not what I was going to say. I noticed when I came in to the work-room you were expressing your feelings about me to the other residents and students.
MR: That's right. I was pissed!
SE: Yes, I really understand that. I can see now how I violated your expectations, and how much that hurt. Still, I'd like to request that, if you have any concerns about my attitude or behavior in the future, you speak with me directly about them. It would really help me get as much as a can out of this clerkship if we had direct communication between us.
MR: Okay, but I call 'em like I see them. If I think you're slacking off, I'll tell you.
SE: That's not a problem. You're my teacher and I want to learn from you, both in terms of the knowledge you have and just how to handle things generally. Peds is pretty challenging, dealing with such sick kids and worried parents all the time.

MR: (Feeling acknowledged) Yes, it can be tough.
SE: Could I ask you one more thing?
MR: Make it quick.
SE: I was wondering if one of the reasons you were upset with me is because you think these events – being late today, not coming in yesterday - mean I'm not taking this rotation seriously?
MR: (Softening just a little) I think you can see how I could draw that conclusion.
SE: Yes, I can see that. But I honestly love Peds, and even considered going into pediatrics. I've really tried hard to learn as much as possible, and take good care of the patients. Has any of this come across to you?
MR: (Thinking) Well, you're not a *terrible* st udent. You did do that extra research on pediatric skin rashes, and there was the night you stayed late with that kid just holding her hand and reassuring her. I guess you've done a pretty good job overall.
SE: Thank you. I really appreciate your being able to see me in a balanced, fair way.
MR: Okay, enough chitchat, let's get to work.
SE: That's a really good idea. Let's go.

In this exchange, SE first figures out her intention, how she wants to behave and what she wants to accomplish. She uses lots of empathy to really see why MR is so upset, and nondefensively acknowledges what she can learn from MR's criticisms. She also nondefensively explains her point of view. Further, she makes a request of MR not to engage in third-party communications about her, but to discuss problems with her directly. Finally, SE encourages MR to reflect on the totality of her performance on Peds, so that she can evaluate her in a more balanced, fair way.

[redacted], I understand that many of the particulars of the exchange above couldn't have happened for one reason or another. All I'm trying to suggest is that there might be alternative ways of dealing with this kind of unpleasant and unfair attack. Please feel free to disagree with me on any of the above or discuss with me further.

I really appreciated your honesty and self-probing. I know you to be a student of absolute integrity and commitment, and I trust that if you were home with the flu, it's because you were really sick. In fact, I think it makes a lot of sense for sick doctors to stay home, especially when they're around vulnerable kids who don't need extra illnesses. And I think there are even some doctors who would agree with me. But the point is not that you're right and she's wrong. The point is that that situation is what you had to deal with, and what would be the way that would cause the least additional suffering and have the best shot at a somewhat improved end result.

Finally, you can't control the outcome, you can't *make* people understand your perspective. But by being calm, centered, empathic, and nondefensive, you can increase the likelihood of this happening. And if it doesn't, and MR is just as nasty at the end of your dialogue as at the beginning, then you have to forgive her for being such a witch, and forgive yourself for not being super-woman medical student.

Shapiro, Johanna

From: [redacted]
Sent: Thursday, December 02, 2004 8:17 PM
To: Shapiro, Johanna
Subject: RE: aod assignment

[redacted]

[redacted] :)

From: Shapiro, Johanna
Sent: Thu 12/2/2004 1:10 PM
To: [redacted]
Cc: [redacted]
Subject: aod assignment

[redacted] you generated a good description of a frustrating situation. I also liked your idea of checking with another study to verify the consistency of the problem. Finally, you were able to analyze why writing in the chart was important to you as part of your medical education.

You generated a number of different possible options that could be charted on a scale of assertiveness, as well as problem-solving a related problem (being put on the spot to generate a differential diagnosis in front of the patient). Some of the strategies highlighted your agenda, others made more room for considering the physician's priorities. This is an excellent exercise in and of itself because it shows that, despite feelings of powerlessness (very understandable, by the way), there are several actions you could take. Even though Dr. S may not be an outstanding teacher, or may be too busy to be a good teacher, you still have the possibility of influencing her behavior to get more of your needs met. The next step would be to consider your various options according to whatever criteria are most important to you – e.g., advancing your medical education, reducing helplessness, learning how to negotiate with superiors etc. And then to ask yourself, knowing Dr. S (even a little), which strategy might have the best chance of success. Very well-analyzed and thought-through. Let us know how it turns out! Dr. Shapiro

Shapiro, Johanna

From: [redacted]
Sent: [redacted]
To: Shapiro, Johanna
Subject: RE: aod assignment

[redacted]

From: Shapiro, Johanna
Sent: Thu 12/2/2004 1:22 PM
To: [redacted]
Cc: [redacted]
Subject: aod assignment

You chose a good example, albeit a very frustrating one because it sounds as though you did an outstanding job on the sub-I, and this resident apparently had to be a spoiler. Your analysis of the situation is well thought-out: You received appropriate recognition for your hard work through the honors designation. The niggling little comment by the resident was really irrelevant, although personally hurtful. There is no right way to respond in these circumstances, but there might be a right way *for you.* The first question you might ask yourself is, Can I let it go? Maybe you feel it isn't important, you'll never see this resident again. If you can accept her negative comment, perhaps you can just move on. However, you may feel puzzled and distressed. Although the comment itself is insignificant, here is someone with whom you worked previously and who seemed "fairly nice," and she suddenly turns into a witch. Maybe you're just curious: Gee, I thought we had a pretty good relationship, but is it just me, or are we not getting along on this sub-I? Are you upset about something having to do with me? Has my work not been satisfactory? Have I let you down in some way? A third possibility is that you might feel it's important to hold this resident accountable for the sneaky way she attempted to undermine your evaluation. Although you probably will never see her again, she may behave in a similar fashion to other vulnerable individuals. So you might want to find out why she criticized your reliability, but had never given you direct feedback. It's all about coming from a calm, clear place, figuring out what you're trying to accomplish, whether it's being assertive *or* being accepting, and then making the best decision you can about how best to reach that goal. Thank you for the obvious thought you put into this essay. Dr. Shapiro

T[redacted]s
[redacted]te
[redacted]

Thank you,
S[redacted]s

From: Shapiro, Johanna
Sent: Tue 12/14/2004 4:43 PM
To: K[redacted]
Cc: R[redacted]l
Subject: patient-related powerlessness

[redacted] the situation you describe is really a tough one. I agree with you completely that what makes it so hard is the unequal power relationships. People with lots of power (and perhaps some of it directly over you) come at you with inquiries in direct violation of HIPPA. It is not unlikely that they choose you precisely because you are low down on the medical totem pole, and are perceived as most vulnerable to pressure. This is unethical behavior on the part of these individuals, especially in the aftermath of your explaining the grounds for your refusal. Clearly anyone would feel frustrated and angry in these circumstances. It was a very good idea to discuss this problem with your team, so that a consistent policy can be established regarding inquiries from friends and co-workers. You've clearly made the appropriate ethical and legal decision not to discuss the patient's situation with anyone except family.

That having been said, I'm interested in the point of view of these people, particularly the attendings. For example, what motivates them to continue asking? I imagine that some of these inquiries might be motivated by physician arrogance. These are people used to being "in the know," and used to having others (especially subordinates) respond quickly and positively when told to do something. There may be other reasons as well. For instance, they may feel helpless and out of control at the serious predicament of a valued co-worker, and they choose their default mode of mitigating these negative emotions, i.e., gathering information. Perhaps they have deeply caring feelings for the patient and the only way they can express these is indirectly, through asking about her medical status.

Who knows? It might be possible to have a conversation with the attendings sharing both your own dilemma and their dilemma: "I can see how concerned you are about Mrs. X. As we've talked about, I really can't answer questions of a medical nature about her condition. But she's lucky to have someone who cares so much about her, and wants to help her. Even though she's in a coma [if this is something you could disclose], it might help to go to her bedside and hold her hand for a few minutes; or visit with her family and tell them how much she means to you." Of course, this kind of dialogue is much easier in the absence of unequal power dynamics.

In any case, this is a situation with multiple

conflicts and one I hope we get a chance to discuss at greater length. Thanks for sharing, Dr. Shapiro

Shapiro, Johanna

From: [redacted]]
Sent: Monday, January 10, 2005 9:16 PM
To: Shapiro, Johanna
Cc: [redacted]
Subject: re: aod assignment

Dear Dr. Shapiro and Dr. [redacted],

[redacted]

Thank you,
[redacted]

[redacted] you've focused on a really crucial issue -the patient's feeling of confusion and helplessness, which in turn trigger helplessness in you. It is an astute observation that silence in some cases can be complicitous. In your example, in effect it could be interpreted as your "siding" with the attending and resident instead of with the patient. You also demonstrated that you had taken the time to understand the perspectives of both attending and resident, so that you did not demonize their insensitive behavior. I'm curious as to whether you would consider discussing this event with either attending, resident, or both. That might or might not be a good idea, but in this way of handling things, you learned quite a bit, the patient also learned a lot, but it is questionable whether resident and attending learned anything. Of course, it is also true that it is not necessarily your job to educate them! This was an excellent example. Thank you for sharing. Dr. Shapiro

Shapiro, Johanna

From: [redacted]
Sent: Friday, January 28, 2005 12:58 PM
To: Shapiro, Johanna
Subject: RE: compassion/empathy essay

[redacted]

From: Shapiro, Johanna
Sent: Thu 1/27/2005 1:32 PM
To: [redacted]
Cc: [redacted]
Subject: [redacted]

[redacted], after our in-class discussion, I think we might have done well to bring a dictionary to our session! What a cool response you provided to my rather prosaic prompt. From Webster's to Lincoln via the internet! Your analysis of Honest Abe's deservedly famous letter is not only creative, but sheds valuable light on our definitional struggles. I particularly liked the emphasis you (and Webster's) placed on the desire to "alleviate" as well as understand the suffering of another. As we discussed, *clinical* empathy is not just an act of imaginative understanding, it also leads to attitudes and actions that attempt to reduce distress. You know, I think the reworking of your last sentence may reveal some ambivalence about the proper role of the physician in relation to his/her patient. In my opinion, that final sentence might best read: "To bring the patient through the struggle, when possible; and to join the patient in the struggle, always." Those are both statements of compassion and commitment. Thanks, [redacted], for your creativity and insights. Dr. Shapiro

Shapiro, Johanna

To: [redacted]

Subject: RE: PD 4 assignments

[redacted], thank you for both of these assignments. I thought your compassion/empathy essay had lots of good insights. I agree that first and foremost is treating the patient as a person - basic, but surprisingly easy to forget about. I've heard many students say that personalizing the patient (what if this were my mom, my brother?) as you describe is a really quick and effective way of remembering to think about the patient's humanity. Your other points are similarly excellent - simple, fundamental things that can be done fairly easily (sitting, touching, asking quesitons, deepening understanding) but really make a difference to the patient.

As we discussed in class, a lot of times *how* you ask the question is as important as *that* you asked the question. When I read your questions, they sounded a bit formal or severe. I suspect this was due to the fact that you had to write them out, and I imagine that in an actual patient encdounter you would phrase them a little differently. Nevertheless, I'm attaching some slightly modified ways of getting at the same issues (all of which were excellent). For example, I always try to avoid "*why*" because it often makes people feel they have to justify themselves. Similarly, a phrase like "fully understand" might put the patient on the defensive. You'll notice that I tended to favor open-ended phrasing, just because it's more likely to get the patient to open up. Just food for thought. Thank you very much for your contributions to this class. Regards, Dr. Shapiro

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From: [redacted]
Sent: Tuesday, February 08, 2005 11:38 AM
To: Shapiro, Johanna
Subject: PD 4 assignments

[redacted]

Shapiro, Johanna

To: [redacted]
Cc: [redacted]
Subject: RE: role model assignment

[redacted], thank you very much for sharing your thoughts about Dr. Zamani. He sounds like a great doctor, and an especially good role model for you since you are going into IM. What I found especially hopeful and thought-provoking was the way he'd taken charge of his practice by trading money for better working conditions and peace of mind. Physicians don't always have this much influence over their work environment, but it is an inspiring reminder that we are not nearly as trapped as we think. There is a great line from a poem by Rumi: "Why do we stay in prison when the door is open so wide?" If we're willing to seriously reexamine our assumptions about "how things have to be," it is almost always possible to discover steps to change things in a more meaningful and more favorable direction. I think I might phrase the take-home lesson you draw a little differently. From reading your account, I don't think Dr. Zamani placed the patients' needs above his own. Rather, it sounded to me as though he recognized that his need to practice good medicine, to have real relationships with his patients trumped his "need" for more money. Perhaps his most important insight was that, by changing his practice, he could not only help his patients but help himself! In any case, Gary, thank you for taking the time to write all this down. I hope in doing so you've engraved all that you learned from Dr. Zamani on your heart, and will remember his example as you proceed through the next years of your training. Regards, Dr. Shapiro

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From: [redacted]
Sent: Tuesday, April 05, 2005 12:20 PM
To: Shapiro, Johanna
Cc: [redacted]
Subject: role model assignment

[redacted]

College of Medicine
University of California, Irvine
[redacted]

From: Shapiro, Johanna
Sent: Wed 3/30/2005 3:35 PM
To: [redacted]
Cc: [redacted]
Subject: AoD meeting this Tuesday April 4

Greetings! This is a reminder that we are having a session this coming **Tuesday April 5 Bldg 56 rm. 114 4-5:30**. If you have not yet shared your personal project, please bring it to this session and be prepared to present it. Also, please write a paragraph (and bring to class) about someone you admire as a role-model (especially as related to doctoring) and why. This individual may certainly be a physician,

Shapiro, Johanna

To: [redacted]

Subject: RE: AoD meeting this Tuesday April 4

[redacted], despite your apologies, I thought this was a really interesting question to raise. It's simple and straightforward, but so is most good research. The obvious question that emerges from your findings is, why do doctors round on patients in the early a.m. if patients are more confused and have less understanding at that time? The obvious answer, as we discussed, is it's more convenient for the doctor! Now, this may be a necessary evil, and doesn't mean the doctor is a bad person for rounding early. But it does mean seriously asking oneself, a) Is there another way to do this that would be of more benefit to the patient? and b) If the answer to (a) is no, then what can I do to make early rounding the least uncomfortable and most valuable for my patients?

The way you formulated your research question and designed your method of data collection were both really nice. Obviously there were many factors that prevented drawing firm conclusions, but you did identify a trend, at least in terms of patient comprehension of their disease. I also thought your interpretation of both data "sets" was thoughtful and honest. The idea that understanding increases not so much by time of day as by repeated exposure to information was insightful, and in fact is substantiated by published studies that show many patients miss abut 50% of information presented by the physician, even if it is presented clearly and well. That finding right there will be important to keep in mind as you begin residency. Patients are not necessarily inattentive or uninterested when they don't seem to remember or understand what you've told them. They just are going to need it repeated more than once. In terms of the question-asking data, I'm not really sure why there was no difference, but I do know it is very easy for our underlying anxieties and pressures to "leak through" into our conscious behaviors. As you suggest, the best antidote is simply awareness ("I tend to rush and be impatient when I have more patients"). And of course, you have to make your own compromises. You *are* busier with more patients, so deciding how to act as compassionately and patiently as possible *under the circumstances* is very individual.

It is often true (at least in my research!) that the most interesting part turns out to be the incidental findings. Yours were particularly intriguing. No matter time of day or questions asked, few patients seem to have a good grasp of the basics of their diseases! As we talked about in class, unfortunately this is not an uncommon phenomenon. As noted above, your interpretation may hold one key to a partial solution - repetition of crucial information. You also make a truly excellent point that patients who have better understanding are not simply "better informed," but also are more patient, happier, and noncompliant. In fact, what you discovered is that "sharing knowledge" although it reduces physician power (in the sense of being the only one who knows what's going on), increases team-building and makes the patient part of that process.

[redacted], I have no doubt that you will make an outstanding and caring physician. Your future patients will be lucky to have you as their doctor :-). Regards, Dr. Shapiro

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From: [redacted]
Sent: Wednesday, April 06, 2005 1:40 PM
To: Shapiro, Johanna
Subject: RE: AoD meeting this Tuesday April 4

[redacted]

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]

Shapiro, Johanna

To: [redacted]

Cc: [redacted]

Subject: RE: Last Assignment

Hi [redacted] Thank you for your thoughts about empathy and compassion. You make an interesting distinction between the two - empathy is the feeling state and perception and compassion is "empathy in action." I agree that for empathy to be of value, it must go beyond feeling into expression, connection, and action. You list several specific ways ranging from the mundane (ice chips) to the systemic (checking malpractice suits) that can incorporate greater sensitivity to the patient's viewpoint and subjective experience. You also emphasize the importance of psychological and psychosocial variables, as well as maintaining an ongoing dialogue with the patient. This kind of awareness will help ensure that you both truly empathize and behave in a compassionate manner. You've thought through these issues carefully and well, and sound prepared to keep a compassionate, empathic demeanor in the forefront of your interactions with patients.

[redacted] this assignment successfully completes your participation in the AoD class. It was a pleasure to get to know you through this experience, and I look forward to working with you next year. Warm regards, Dr. Shapiro

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From: [redacted]
Sent: Sunday, April 10, 2005 5:56 PM
To: Shapiro, Johanna
Subject: Last Assignment

[redacted]

[redacted], I'm happy you found it useful to focus on your example in class. I personally thought it raised fascinating ethical and moral issues. Like you, through the discussion I realized I had been thinking too narrowly about the situation, and comments from others helped me to broaden the range of possibilities and how I might go about addressing the problem. Also, with reference to your comment below, I'm a big proponent of dialogue, but at the same time I recognize that engaging another may not always be practical or worthwhile. On the other hand, sometimes when we initiate that conversation, it can be pleasantly surprising where it takes us (and it can be negatively surprising too). This is one of many situations where, darn it, I don't think there is one right answer (although if pressed I'd guess b). I think the best we can do is use reflection to guide us to the best choice possible under the circumstances. Thanks for carefully listening to my comments and to the class back-and-forth. It made for a very interesting and worthwhile afternoon. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Monday, January 10, 2005 9:16 PM
To: Shapiro, Johanna
Cc: [redacted]
Subject: re: aod assignment

Dear Dr. Shapiro and Dr. [redacted],

[redacted]

Thank you,
[redacted]

[redacted] you've focused on a really crucial issue -the patient's feeling of confusion and helplessness, which in turn trigger helplessness in you. It is an astute observation that silence in some cases can be complicitous. In your example, in effect it could be interpreted as your "siding" with the attending and resident instead of with the patient. You also demonstrated that you had taken the time to understand the perspectives of both attending and resident, so that you did not demonize their insensitive behavior. I'm curious as to whether you would consider discussing this event with either attending, resident, or both. That might or might not be a good idea, but

Shapiro, Johanna

To: [redacted]

Cc: [redacted]

Subject: RE: Tuesday's with Morrie

[redacted] thank you for reflecting on your reactions to the play Tuesdays with Morrie. I was very intrigued by your perspective. A lof of people talk about how the story is an example of the patient as teacher; or how Mitch learns about humility, patience, and what is really important in life. These, and other insights, are quite true. But I really like what you say below about the play modeling a "dignified death." So many patients suffering with terminal illnesses hope for this in their final passage, but as you observe, it rarely happens, especially in a hospital environment where everyone is bent on doing "everything possible." What struck me particularly about your comments is the realization that it is up to the patient, as much as the physician, to say enough. Patient (or family, if the patient is too incapacitated) and physician must act in concert, as partners, to face the end of life with clarity and grace. In order to do so, they must first be able to honestly and directly communicate with each other about this difficult, but critical subject. Perhaps, if anything positive is to come of the Schiavo fiasco (which would have made good absurdist theater, if so much of vital importance wasn't hanging in the balance), it will be that people in all professions and walks of life become less afraid to talk about death and dying, what they expect, what they fear, and what they desire. From these conversations, it is not too much to hope that dying, while not free from suffering, can be a humane process, instead of one that leeches the humanity out of the patient! I really appreciated your thoughts, Gary. Dr. Shapiro

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From: [redacted]
Sent: Sunday, April 10, 2005 12:50 AM
To: Shapiro, Johanna
Cc: [redacted]
Subject: Tuesday's with Morrie

Dear Drs. [redacted] and Shapiro,

The following are my reflections on the play Tuesday's with Morrie. Thanks for reading it, and I'll definitely see you this coming Tuesday.

-[redacted]

Mitch Albom's Tuesdays with Morrie
Long Beach Playhouse
Saturday, March 26, 2005

[redacted]

Shapiro, Johanna

From: [redacted]
Sent: Friday, December 03, 2004 11:46 AM
To: Shapiro, Johanna
Subject: RE: [redacted]

Hi Dr Shapiro-

[redacted]

From: Shapiro, Johanna
Sent: Thu 12/2/2004 1:28 PM
To: [redacted]
Cc: [redacted]
Subject: aod assignment

[redacted], thank you for sharing your example with the group. It made for a very interesting and useful discussion. Partly I heard it as a boundary issue. In an assertive but polite way you were drawing a line. That is never an easy thing to do and often, no matter how well you do it, people don't like it. You also have a terrific insight that making a good impression is not necessarily contingent on doing "whatever the person asks." However, as the discussion indicated, the problem came in when you felt compelled to "apologize" for setting a boundary. Retrospectively, you realized that a) apologizing didn't make the fellow respect you more and b) you lost some self-respect in your own eyes. It sounds to me as though you are a work in progress ☺ By your own acknowledgment, you're "getting better" at asserting yourself, but you're still doing some second-guessing. In psychological terms, your effort would probably be called a successive approximation. You took an important step in showing you can be a dedicated learner and a hard worker who also has the ability to set limits when appropriate (for both self and, in this case, others). True, you undermined your own credibility a bit with the apology, but that probably occurred because you got afraid of your own power. The most important thing was that you analyzed the situation independently, reached what you felt was a valid conclusion, and acted on it in a polite, thoughtful, but firm manner. I'd say, congratulations! Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, April 13, 2005 11:46 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Make-Up Assignment

[redacted], thank you very much for this thoughtful essay about the "merciful cruelty" of the ICU (I've never heard that expression before, it's very apt). The example you give is a particularly harsh one, because it seems the family is not motivated by affection but by mercenary self-interest. However, I've heard similar wrenchingly painful stories where it is not greed but an excess of love that makes it impossible for family members to let go. Your reference to the Terry Schiavo case is very apropos I feel. Regardless of one's political persuasion, I think the last thing most of us want is the government making decisions about our last moments. If the government can't run an efficient postal service, I for one don't want them directing my end of life care! In part, I think that whole fiasco highlights some of the problematic consequences of our death-avoidant culture. If we could all move a little closer to death and incorporate it as part of the life cycle, perhaps we wouldn't be so afraid and confused when we actually ran up against it. The word I liked best in your essay was when you said, "I will **caringly** ask.." your patients to complete advanced directives. If you guide your patients with care and love, even in this most difficult of areas, you will help allay their fears and help prevent tragedies like Mr. M and Terry Schiavo.

[redacted], thank you also for your very kind words about what the AoD class has meant to you. I was very moved by what you shared. Of course it is the dream of every professor to play a small part in helping students to realize their potential and continue to evolve as learners and as people. It means a great deal to think we've been able to contribute to that process in your life. May you have great success and happiness next year, and in the years to come. Warm regards, Dr. Shapiro

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From: [redacted]k
Sent: Tuesday, April 12, 2005 2:38 PM
To: Shapiro, Johanna
Cc: [redacted]
Subject: Make-Up Assignment

Hi Doctors,

Here is my write-up to make up for my final attendance. I hope it is what you were looking for. If not, please let me know and I will work on it to make it satisfactory for the course. Thanks for everything.

[redacted]

Hi [redacted]. Thanks for coming to class yesterday. I know it required some extra effort to haul down from Long Beach. I'm sorry we didn't have a chance to discuss your cases, which I found engrossing. Here are a few comments to compensate!

Assignment #1: Drug-abusing mom and drug-addicted infant.
Of course your natural empathy and concern was with the innocent victim (the baby). At the least, this is not anyone's idea of getting a good start in life! I wondered if you had more information about the discharge plan. It bothers me as well that the baby was being sent home under such circumstances. Maybe there is more here than we realize. If the mom tested positive for drugs, maybe the situation will be monitored by Child Abuse Services. Maybe a requirement of placing the baby with the parents is that one (or both as the case may be) complete a rehab program. It doesn't seem well thought-through to just let the baby go and hope for the best!

But the deeper reality is that, even if there were some safeguards in place, this kid is still going to be at-risk, and that is truly heartbreaking. Even when, as the responsible professional you've done all that you can, you may often be left with feelings of doubt or anxiety that the solutions you've so carefully helped to craft will hold. That's when you have to learn to let go, after you've done all the instrumentality you can do, to release this baby – and his parents – to their future. I think this is what Iris meant by acceptance. It is a hard lesson to learn.

I also liked the fact that you considered how difficult it would be to follow a drug-addicted woman through her pregnancy. Although the woman is clearly your patient, at a certain point the baby becomes your patient too. There's actually an interesting literature on this topic that ranges from enforcing criminal penalties for women who use-while-pregnant to working through the physician-patient relationship to persuade them to get clean. The solutions are not obvious, nor simple.

Assignment #2: Woman who is angry about STD screening
This was another great situation (although I'm sure less great when you were in it – I'm glad she didn't actually assault anyone!). Reading about the patient's reaction, I did wonder about her mental stability. Still, whether or not there is a psych component does not solve your problem. It might be useful to reflect on what might have made the patient react so strongly: 1) Mental illness, as above 2) Hyper-strict upbringing that socialized her from an early age to think that sexually transmitted diseases and perhaps sex in general were signs of an immoral, "dirty" person 3) Other hypotheses. In any case, it can also help to ask yourself whether your anger at the patient's judgmentalness is useful and why it arose in you. It sounds as though you were responding protectively regarding other patients who you know to have STDs and who are still good, moral people. My guess, however, is that in this situation what's most important is not what your patient thinks about other people, but what she thinks about herself; and that is likely that, if she did have an STD, she would automatically be viewed, and view herself, as a horrible, worthless person. (You yourself arrive at this possibility in your next to last sentence). This interpretation, whether compounded by mental illness or not, might help trigger compassion: "How awful it would be if, just because this woman was diagnosed with Chlamydia, she thought of herself as scum." In this light, the goal is probably going to be reassuring the patient that she still matters, that she can still be a good mother whether or not she has a diagnosable STD, and helping her to heal whatever emotional wounds she has received around sexuality and sexually transmitted diseases.

What to me was even more disturbing was your physician's use of the word "clean." Now, unless he also suffered from mental illness (!), I can think of no mitigating circumstances to ease the insensitivity of this remark. You are quite right that it is this kind of judgmentalness that drives STDs and other stigmatized conditions underground. This physician needs reeducation at least as much as your patient does, if not more so, because he holds a position of authority and influence where his prejudicial attitudes are likely to do more damage. Imagine if you were his patient, heard that remark, and later contracted what you thought might be an STD. How likely would you be to go back to him?!

As always, [redacted], you write well and thoughtfully. Thank you for reflecting on these incidents.
Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: [redacted]
To: Shapiro, Johanna
Subject: [redacted]

Dr. Shapiro,

[redacted]

From: Shapiro, Johanna
Sent: Tue 1/4/2005 7:05 AM
To: [redacted]
Subject: meeting reminder

Hi everyone. Hope you've had an enjoyable and relaxing break. Since there's been some schedule shifting, we wanted to remind you all of the following Art of Doctoring meeting dates:

Tuesday Jan 11 4:00 topic: dealing with patient-related feelings of helplessness, frustration (continuation our last December session)

Tues Jan 25 4:30 (note late start) topic: centering, compassion, and empathy

There will be ***no sessions*** Tues Jan 4, Tues Jan 18, or Tues Feb 1.

Looking forward to seeing you all, Drs. Shapiro and Robitshek

[redacted], I appreciate your sharing this concern: ie., focus on negative emotions engenders more negative emotions. This is an excellent insight. I do think there's an answer. If you're coming to class next Tuesday, maybe we can talk for a few minutes afterwards. In any case, let me suggest briefly that it depends on our *relationship* to our negative emotions. If we take the attitude "our emotions are our reality" then we tend to fuel the emotions with cognitions and stories: "Hmm, I'm sad. Gee, noticing that I'm sad is making me even sadder. And boy do I have a right to be sad because I just blew my fm shelf exam, my girlfriend dumped me, and I haven't slept in 3 days." Etc., etc. There are other ways of looking at emotions (and thoughts for that matter), not necessarily as unchangeable truth, but simply that – an emotion, a thought. The value of becoming aware of negative emotions is that we begin to know them well, we begin not to be so afraid of them, and we begin to not let them have too much influence over our lives. For example, "Ahh, sadness, my old friend. I see you're back again. Well, let me see. Is this the garden-variety sadness or is it that deeper life-isn't-worth-living sadness? Are you here for a good reason, maybe to remind me to grieve the loss of my girlfriend? Well, that's something I really need to do. Are you here to get me to flagellate myself over the shelf exam, which nothing can be done about now? Well, maybe I don't want to do that."

On the flip side, I think "happiness" or "sadness" are often choices we make. If I think about my life, for example, there are always reasons why I could be sad – or very sad. But of course there are things that I could be happy about. So it's a lot where I choose to put my focus. And this is a lot different from "stuffing" negative emotions – it's rather saying, "I know you, I see you, I understand you, but right now I do not choose you. I choose gratitude (or joy or whatever)." In my religion, it is considered a spiritual requirement to be joyful on the Sabbath, even if something terrible has happened. For 24 hours, we are required to focus on joy, gratefulness, the good in life. Then we can go back to being curmudgeons! Hmm... I hope you get the idea. Maybe I can explain it a bit better if we chat. Anyway, I appreciate your trust in raising this issue, it is certainly one with which I am personally very familiar. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Sunday, December 05, 2004 4:16 PM
To: Shapiro, Johanna
Subject: RE: aod assignment

[redacted]

From: Shapiro, Johanna
Sent: Thu 12/02/04 13:19
To: [redacted]
Cc: [redacted]
Subject: aod assignment

[redacted], youâ€™re putting your finger on a paradox of medical education. We specifically select individuals for medical training who have high need for control, then put them in a situation where, for four long years, they have almost no control at all! Personally, I think it is an unhealthy situation when you