M 1.10.AoD
2.1.10
Comment 1
It is so difficult under the best of circumstances to navigate a life-threatening illness in a child. How much more so when struggling with language issues, especially unrecognized ones! (of course, the worst kind).
Comment 2
I can imagine how desperately, as an engineer, he must have wanted to use “information” to feel he was in control of the terrible things that were happening to his son.
Comment 3
Interestingly, I have heard other parents make similar, seemingly irrational statements. I’m not sure whether they are actually true on a literal level; but more a (very understandable, but hopefully temporary) inability to accept the reality of a severely mutilated child.
Comment 4
This is an interesting possibility which hadn’t occurred to me, but makes some sense.
Comment 5
I suspect that the root “frustration” (more likely incredible rage and helplessness) was with the horrible things that were happening to his son. You all were just the convenient target.
Comment 6
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 7
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 8
This is really a good insight,. 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 9
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 10
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 11
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!
Comment 12
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

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M 1.11.AoD
1.28.11
Comment 1
I respect how much you learned about the daughters situation.
Comment 2
this is so insightful – both that the caregiver was laboring under certain stressors that contributed to her challenging behavior; AND that the team did not take the time to understand what was driving her behavior and therefore avoided and rejected her
Comment 3
Very understandable. It sounds like the caregiver, because of her own situation, was very demanding; and that the team essentially had abandoned her.
Comment 4
This is such a beautiful transformation, Aaron. We often will still experience resentment or impatience at times – after all, we are only human! – but understanding what drives another's difficult behavior can soften our emotions by mingling them with greater compassion and empathy.
Comment 5
And once we start to feel more positive anticipation and less resentment, the encounter itself becomes more meaningful and worthwhile.
Comment 6

Yes, unfortunately it is in our immediate self-interest to do so, because then we can rationalize not dealing with the situation.

Comment 7
A very wise insight. Even if you aren't a family doctor, you are ALWAYS treating not only the patient but the patient's family. And what is going on with that family will certainly affect the patient's healing
Comment 8
Sometimes when you are exhausted and stressed, even taking a few extra minutes can seem like a huge sacrifice – so we rationalize that the patient or family member doesn't "deserve" it. But in fact they do – always. And when you actually take that time, you discover that the cost to you isn't as much as you feared, and the benefit to the patient or family member is (often) much greater than you anticipated.

M.1.12.AoD

1.31.12

Comment 1

What I find incredible is that the senior resident didn't simply say, "There are some shortcomings in the consult note, let's go over it so this can be a learning experience." No need for pimping, no need for punishment. Why is an opportunity for learning transmuted into a shaming and blaming session?!

Comment 2
This is disappointing. You protected her, but she also chose to protect herself. However, I fault the resident as well for creating a toxic atmosphere that made it so difficult for your med student partner to admit what was a mistake in ignorance or at worst inadequate effort that could certainly be remedied.
Comment 3
I find this very surprising as well. Again, it seems to me that the resident's display of anger, resulting in humiliation and punishment, created an atmosphere which encouraged self-protection and lying by omission. This is a sad example of how unregulated emotion can reverberate negatively within the team, with highly unfortunate consequences.
Comment 4
In the face of such inappropriate behavior on the resident's part, I can't help wondering how else this situation could have been handled. You were the accidental victim of the resident's misplaced rage, but even if he'd directed his anger at your medical student partner (the person whose consult note was apparently inadequate), this kind of pimping and abuse is simply wrong. I know medical students often choose to absorb this kind of treatment because they figure they will soon be off the service, and this is true, but then the abusing resident learns nothing and is never challenged. I wonder if you could have enlisted the help of the chief of the service, or the clerkship director. Could you have discussed the situation directly with the resident? Perhaps with your partner, and both of you (safety in numbers) meet with the resident? I'm sure ho easy solution was available. It is so frustrating to hear of this kind of unfair and completely unprofessional treatment which, as you know, sadly is not uncommon.

F 1.13.AoD
12.10.12
Comment 1
Absolutely. These experiences, as difficult as they are, continuously shape us as physicians.
Comment 2
I think this is still the most difficult conversation for most of us. As we move away from a "technical" conversation to a more human one, our own emotions and thoughts about mortality surface.
Comment 3
You were clearly recognized the tensions between the patient and family's wishes…they were having a hard time letting go, it seems.
Do you think that the being close to the daughter's age affected how you felt?
Comment 4
Those small kindnesses go a long way!
Comment 5
Yes, and it doesn't stop after medical school. We keep on learning, every time we take care of someone, as long as we continue to be fully present and pay attention, as you clearly did very well in this encounter!

M 2.10.AOD
2.3.10
Comment 1
Yes, direct confrontation with the offending individual is not ever the only option, and it is by no means the right one. In this case, approaching a supervisor would make a lot of sense
Comment 2

Wise insight. Escalation is always an option, but when it is done mindlessly, it usually only adds fuel to the flames.
Comment 3
Absolutely. The goal is neither to explode in anger nor cower in fear. The goal is exactly what you state – to honor your principles and preserve your integrity. Once you are clear in this, the correct behavior becomes clearer.

F 2.11.AoD
1.28.11
Comment 1
Sadly, in my experience you are correct. With almost 40 million Americans still uninsured (although hopefully that number will start to decrease if health care reform is not sabotaged), many people delay treatment for fear of cost.
Comment 2
And how ironic that when disease becomes emergent and critical, then uninsured patients are often eligible for services.
Comment 3
I think you've identified the "take-home" lessons very well in this case. Whatever the circumstances, the patient in the present deserves care and understanding: she also, as you note, deserves to have her story heard. As a physician, such stories create an obligation in you (at whatever level you choose to accept it – and really all of us!) to advocate for more fairness regarding access to healthcare.

F 2.12.AoD
3.15.12

Comment 1
I appreciate that you hear where the nurse was coming from, but it isn't pleasant – or right – to be blamed for others' mistakes. I imagine this nurse had a long history of "cleaning up" after med students, but there are more professional and kinder ways to convey the same message
Comment 2
Basically, your strategy was one of defusion, often an excellent strategy: 1) Empathize with the person ("It must be so frustrating to clean up after us med students!" 2) Acknowledge their point of view ("I agree it's not right to leave a mess for others") 3) Agree if appropriate ("("I appreciate your bringing this to my attention") and then, and only then, if appropriate, 4) Make your own point ("I just want you to know this is not who I am, and I would never have done something like this, even without the warning")
Comment 3
And a very unfortunate hierarchy it is, both in terms of the top-down nature and in terms of the yelling! How about calm, respectful exchange of views anyone?!
Comment 4
I doubt it was worth it in this particular situation, but sometimes it is worth revisiting an event after tempers have calmed. In this instance, at the end of the rotation, you might have said to this nurse: "Remember that first day, when you told me to clean up after myself? That really stuck with me, and I tried throughout the rotation not to make more work for you and other nurses. So thank you. I also wanted you to know that I did feel a bit yelled at for something that wasn't my fault. Perhaps there's a better way to give other medical students the same message in the future."
Comment 5
This is perhaps the best lesson: be the change you want to see. As you rightly observe, this unprofessional conduct is part of a larger systemic problem in medicine.

F 2.13.AoD
11.28.12
Comment 1
Love it! (not that you couldn't stand your patient, but I love your honesty). As we discussed one session, it is important to be honest about what we're feeling and not minimize or ignore
Comment 2
Exactly, and you are right, both you and many others "have seen it before." So the interesting question becomes, what CAN you do for her?
Comment 3
Yes, this is often the best explanation we can offer.
Comment 4
Good for you, being open to all possibilities is always a good way to start.
Comment 5
And this is a good distinction you were able to make – you couldn't empathize with her current behavior, but you did have empathy for a traumatic event in her past which was likely still influencing her present day demandingness and neediness.
Comment 6
You had an excellent role model in this case, who attempted to shift the patient's thinking in a more positive direction. It doesn't always work – and for sure it's hard to do in a single encounter. One hopes that her no doubt exasperated primary care physician has the skills to address her somatizing tendencies with compassion and patience.
Comment 7
Well, if you'd had the opportunity to follow the patient (not that you'd want to!), at least this might be common ground that you could build on.
Comment 8
thank you for sharing so honestly about this obviously very frustrating patient. I think somatization disorder (or psychosomatic illness, if she didn't meet criteria) is actually not easily or successfully handled in the inpatient setting. It really requires a long-term approach, involving a balance of both supporting and challenging the patient. In some cases, you have to forgive yourself for not finding a way in to the patient; and to forgive the patient for being so hostile and resistant. Not all stories have a happy ending, although as you were aware, the attending in this case seemed exemplary in the way she interacted with the patient. Over time, that style of interaction could reap rewards.

M 3.10.AoD
9.3.13
Comment 1
what a creative way to define this assignment! You are absolutely right that "difficulty" includes all sorts of situations – a demoralized pt, a dying pt, a pt you really care about to whom you have to deliver bad news. Medicine is often a hard profession – but the very fact that you have the opportunity to connect with – and sometimes even make a difference with – these patients is actually a privilege (although admittedly sometimes a hard one!
Comment 2

Again, great insight. What can be "difficult" about medicine is that it is not a perfect science, and it does not promise happy outcomes no matter how "good" pt – and dr – are.
Comment 3

I see how you could feel this way. I guess from my point of view, it is not that medicine “failed,” but that medicine has limitations.

Comment 4
What a painful conversation! (and especially as a “second look” applicant!). HOWEVER, again just from my perspective, I think the situation called not for distance, but for connection, which you had the courage to offer the (not even really “your”) patient. The conversation you had with Luis was a wonderful example of facing the limitations of medicine honestly with the patient; and not abandoning him in the face of a very difficult situation. In my view, you were a true physician with this pt. You gave him truth and comfort, and that is what you had to give.

3.11.AoD
2.1.11
Comment 1
Ouch, this is horribly cynical. It is one thing to need to keep your practice afloat, another thing to have the primary focus be on making money.
Comment 2
An example of where the lowly medical student is wiser than the doctor – clearly, this is the underlying issue that needs to be addressed
Comment 3
True, it was an awkward situation – very! But I think you should have felt proud – you were advocating for the patients, while risking the enmity of your physician supervisor. That takes courage!
Comment 4
It is probably not a conversation that needs to occur IN FRONT OF the patients; but bringing to this physician’s attention that he may not have the resources/information to adequately care for uninsured patients is absolutely the right thing to do. Raising the issue at least forces him to examine his own behavior, if only for that moment. Otherwise, if no one says anything, his poor clinical practices will simply persist.
Comment 5
I think you are too hard on yourself. I'm very admiring that you did speak out to correct this physician's approach with these uninsured patients. It is very difficult to challenge authority, even when you know in your heart they are doing wrong. You were able to step up and tackle the issue. This was the morally right action to take. Could you have confronted the physician even more strongly? Perhaps. But I think the main thing is that you were willing to question business as usual. All best, Dr. Shapiro

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F 3.12.AoD

No date

Comment 1

IM is a stressful rotation. You learn a lot, but a lot is expected of you!

Comment 2

That must have been so frustrating! All that preparation only to be interrupted and dismissed as the lowly med student who couldn't possibly have anything worthwhile to say

Comment 3

I think this is a very common response in people with less power when the person with more power is displeased - i.e., blame yourself! That suggests that if you just try harder, you can change the outcome

Comment 4

I'm not sure this strategy - which seems a bit passive-aggressive - is ideal either

Comment 5

Exactly, I think this sarcastic statement well captures your frustration and helplessness

Comment 6

Wonita, I am so sorry. What an incredibly aggravating experience that also shortchanged you on learning

Comment 7

Yes, this would have helped. Since the other student also received the same treatment, this was obviously not about you personally

Comment 8

Well, this is quite possible, and of course focusing on learning is never a bad thing

Comment 9

I think you are quite right that sometimes you must just accept the situation as it is and make the best of it, without allowing yourself to feel too personally diminished. I'd like to offer an alternative perspective as well, keeping in mind that you were there and I wasn't, so my thoughts really might not apply. Nevertheless, I was struck by this new attending's lack of skill in including the medical students in the patient care process, and suspect it may have had to do with his own inexperience. He might improve with time, but you certainly describe some unfortunate habits that might only become entrenched with time. I wonder what would have happened if you (and the other medical student, if you could have enlisted her cooperation) had politely and respectfully pointed out that the attending always interrupted your presentations. Perhaps the attending was not even consciously aware he was doing this! He might simply have continued down this same road; but hopefully he could have considered this feedback and made some positive adjustments. It is so hard to take this kind of risk as a medical student. But I hope when you are a resident - and an attending! - you will remember to create a safe environment where even lowly medical students can approach you with their concerns.

M 3.13.AoD
9.2.13
Comment 1
What a wonderful resolve, especially as, in this case, you were filling a very noticeable gap!
Comment 2

It is true that some patients can be very demanding. But when we start think of them using such negative metaphors as “black holes,” we reduce them to an entirely negative entity that deserves to be dismissed or

ignored. Before using such judgmental language, we need to think about its implications for how we view and treat patients.

Comment 3
And thus the cycle begins. The patient expresses frustration toward his doctors. His doctors, instead of trying to understand and address this frustration, label him “difficult” in retaliation. It’s a stalemate, with little possibility of forward movement.
Comment 4
Mediating between different parties and different viewpoints can be very effective, but only when those involved have agreed to cede a certain amount of authority to the mediator. Otherwise, it’s a position of futility
Comment 5
It sounds as though you seized this chance to reach out to patient and family and help prepare them for the challenges they would face in the future. Good for you
Comment 6
It is frustrating indeed when people fail to see what’s right in front of their faces because it challenges their assumptions, practices, and ways of being in the world. Anais Nin wrote, “We do not see things as they are; we see things as WE are,” and there’s a lot of truth in this. We can be blinded by our own fears and attachments, which may well have been the case for your surgeon attending. It would have taken both a lot of humility and a lot of courage for them to admit they you, a lowly third year student, had something to teach them.
Comment 7

I hope as well that you will not give up on your future colleagues; but will be both patient and persistent in sharing a more humanistic approach to patient care that remembers that patients are human – and so are physicians.

M 4.10.AoD
2.7.10

Comment 1
Can’t understand why this was challenging. Most docs find such patients so easy! :-)
Comment 2
As we discussed, ideally you would want to create a therapeutic framework (i.e., contracts, shared understandings etc.) within which the pt’s addiction could be addressed. Within that framework, refilling a narcotic prescription can make sense (at a certain early point in the relationship). Without it, the dr is sadly just moving those deckchairs.
Comment 3
As you know, because of controlled substance prescription registries, it is not quite as easy to move from dr to dr getting narcotics (but it’s still pretty easy). And you are certainly making a good point about the pt’s pain. Ideally, you want to develop a plan (possibly involving a chronic pain clinic) to deal with the pt’s pain (organic or functional), not simply refuse refills. But as you’ve seen, it can be a challenge to do this in a busy clinic, especially if the patient has very little interest in going along.
Comment 4

I’m really with you on this one. It’s not the easy way out, but I have seen this done extremely skillfully by primary care physicians. Even with all the effort in the world, these situations don’t always have happy outcomes; but if the effort isn’t made, there is no possibility at all that the pt can be helped.

F 4.11.AoD
2.1.11
Comment 1

Red flags, red flags! I'm always interested when there is this kind of common knowledge, but the problem itself is not addressed. I wonder if other students had expressed concerns to the rotation director about this intern. It sounds as though she could have benefitted from some attention to her teaching style and patient care.

Comment 2
Ouch! To my layperson's ears, this sounds both insensitive and unnecessary.
Comment 3

So you two stayed to show solidarity and lend support, and she responded by attacking you!

Comment 4

So by interrupting, she actually misconstrued what you were about to say.

Comment 5
Yes, this is a bad pattern that entitled people can fall into: Rather than expressing appreciation for what they do receive, they are always looking for what was missing. "The one thing I really wanted…" There are certain people for whom, no matter what you do, it is never enough.
Comment 6
I think this is a generous, and often appropriate response. It depends on what "if I can" means. You will always have conflicting priorities. Sometimes you have to honor your own needs, sometimes you can sacrifice your needs for another
Comment 7

In my view, this is a more nuanced approach. It is not ONLY about your rights; and it is not ONLY about being helpful to others. There has to be a balance, depending on the circumstances.

Comment 8
How can this situation be resolved? Although the intern does not know it, she is shooting herself in the foot. By behaving rudely and meanly, she is depriving herself of extra help and support. If you sat down with her and had a conversation (My nature is to always be helpful and go the extra mile, but sometimes working with you I'm afraid to do so because you don't seem to acknowledge this extra work and are often short or sharp with me. I want to have a good working relationship with you, where we come together to do the best possible for the patients? How can we improve things?" This might only annoy her further, but it gives her an opportunity to change her behavior, and make this better for everyone – including the patients!
Comment 9
Thank you for sharing this frustrating and confusing experience. I hear your uncertainty that you could have done anything deifferently; as well as your ambivalence about what is the "right" thing to do - try to help out regardless or stick up for your rights. I agree it's quite complicated. Personally, I favor a more "situational ethics" - it kind of depends on the circumstances, yes? Sometimes you need to go that extra mile, and sometimes you need to take care of yourself. It can't be all one way or the other. I wonder in this particular case whether it might have helped to try to resolve the underlying issue - i.e., that you were reluctant to provide extra assistance to this intern because she was so punishing and unappreciative. Perhaps if you had been able to confront her attitude (not with hostility, but with a desire for understanding), it might have helped you see more clearly what would be the appropriate thing to do. It

also occurs to me that, since so many people were aware of the intern's unprofessional behavior, which seemed to be cross-situational, it might make sense to discuss the problem with someone higher up the food chain - not to complain about the intern or get her in trouble, but to get her some help so that her bad habits with patients and students did not continue. Just a thought. All best, Dr. Shapiro

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F 4.12.AoD
4.2.12

Comment 1
I am so sorry, Didi. From what I hear from students, the first experience of a patient's death is almost always distressing. In my view, as it should be, especially when you've formed a personal connection with the patient
Comment 2
This does make it worse, it seems to me. Death may be inevitable, but the manner of death may present opportunities for the medical team to provide comfort and relief of pain. When this doesn't happen, it must be such a helpless feeling.
Comment 3
I respect that, despite your own discomfort, you did not simply "move on," but instead "reflected deeply" . This can be hard to do, but it's how we learn. As you obviously did.
Comment 4
And this, in my view, is the best gift you can give this patient.

F 4.13.AoD
1.17.13

Comment 1
I'm late in reviewing your "Reflection on a difficult patient", and I apologize. Please forgive me. It is a great description of two difficult patients.

Your essay beautifully expresses your frustrations with these two patients. And also your feeling of the lack of respect that you deserved. There was frustration that the patients didn't want to listen to your help and guidance, which was clearly in their best interest.

So what are the lessons to be learned? 1) We are the wrong person to be talking at that moment if the patient does not want to hear what we have to say. 2) The patient is the one who needs to do the talking.

The "difficult patient" is the one to whom we need to listen, without replying. Just attentive listening.

Their negative attitude is really at their own medical problems, but misdirected towards us. We wish to address just the disease. They want to talk about themselves and how much they hate their illness and the problems it is causing them (drug addition, cancer, dying, chronic debilitating illness that saps away quality of life, etc.).

Empathetic listening to their story is the best medicine you can provide at that time. Show respect by listening with understanding about how they see their illness. Allowing them to "get it off their chest" is the best treatment. This will gain their respect. Then they can proceed in taking your advice. Your relationship will shift from negative to positive.

If the patient doesn't want to talk (i.e. listen to you) don't take it personally. It is really the patient's problem. Try to find out what their thoughts are. Then give your message at the end. It will be received better.

It's about shared decision-making. You know your message (agenda). But we must learn the patient's agenda also. Then we can blend the two. Win-Win. And tons more fun !!

I'd be glad to hear more from you about this, or anything. So don't hesitate to contact me .

5.10.AoD
2.1.10

Comment 1

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 2
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 3

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.
Comment 4
Hi=, 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

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F 5.11.AoD
Comment 1
Interesting that even when you were the one at risk, you took so much responsibility. I wonder that the R3 was silent.
Comment 2
That was, of course, the right thing to do. I'm curious as to whether the resident apologized in the presence of the attending.

Comment 3
Okay, now even I'm starting to feel sorry for this guy.
Comment 4
That's so interesting – your biggest worry was interpersonal, i.e., that the resident's guilt or anxiety would affect your relationship.
This is an interesting approach. I wonder if there was a way you could have continued to work together, ACKNOWLEDGING the incident, with the R3 managing to forgive himself for his mistake, and you forgiving him. Sometimes "pretending" can create a falseness that leads to its own difficulties, because both parties know the truth at some level. In this case, however, it seemed to work for you both.
Comment 5
Were you concerned that the team didn't take your fear/distress seriously enough? It sounds like procedurally everything was done properly. But sometimes too quick reassurance cuts off the possibility of expressing one's emotions. When someone tells you there's "nothing to worry about," it makes it harder to say, "I'm really worried."
Comment 6
Despite how nice and kind everyone was – and they were, as well as efficient and responsible – it sounds like you might be left with a little tinge of dissatisfaction. I suspect this is because everyone put so much energy into telling you that there was such a low likelihood of infection that you didn't really have an outlet to express your distress (a very legitimate distress, I might add, even though the objective risk was low with this patient. A needle stick triggers feelings of vulnerability, and ideally these should be addressed as well as the more instrumental steps that must be taken.
Comment 7

thank you for sharing this difficult incident (which by the way, you recounted in a very entertaining manner, especially given the potential gravity of the situation). In my opinion, a needle stick accesses feelings of vulnerability, no matter how low the "objective" risk involved is. Reassurance, while meant to be, well, reassuring, can often cut off our feelings. Thus, when you tell a patient too quickly, "Don't worry about it," if the patient doesn't feel her concerns have been heard and taken seriously, her emotional processing will be short-circuited and she will feel that this issue has been incompletely resolved. Something similar may have happened to you, even though everyone was just trying to make you feel better.

I also thought it was interesting that what worried you the most was not the possible medical consequences of the needle stick, but the interpersonal ones. In this case, you and the R3 chose to "pretend" the incident never happened, and this allowed you to return to the pre-stick relationship. This strategy seemed to work for both of you (perhaps along the lines of no harm, no foul), which is what counts. However, it might be worth considering that sometimes "pretending" difficult things didn't happen can be less successful, because we can't really put them aside, and they continue to leak into the relationship and distort it. In this case, despite some aspect of "pretending," the R3 did apologize frequently and profusely; and you were able to accept his apology, which suggests to me that, at least to some extent, you both were able to confront what had happened and address it.

I hope there is no negative fall-out for you from this unfortunate episode, either physically or emotionally. I think you handled yourself very well, pragmatically and courageously. Luckily in this case the risk to you was very low, but that doesn't change the fact that you assumed risk in the act of helping another. It is just part of being a doctor, but I personally find it very admirable. All best, Dr. Shapiro

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M 5.12.AoD
5.25.12
Comment 1

It is unfortunate that this factor drives discharges….
Comment 2
Which, as you and your team learned the hard way, is just that: preliminary!
Comment 3

Do you think the gravity of this situation might have made a phone call more appropriate?

Comment 4
I think even later in the year, one is taking a risk with prelim readings. It is okay to let the patient know that the final reading is not yet available….that is safer for all concerned!

AOD Essay
12.2.12

Comment 1
This is both useful on a content level of giving the patient useful knowledge; and on a process level of demonstrating willingness to share the power inherent in information; and as a sign that you respect the patient and are motivated to make them an equal partner in decision making.
Comment 2
Exactly – well said. If I can say to myself, "I am enduring this pain because of x,y, and z," it makes it easier to bear than if I have to say, "The doctors have decided this has to happen to me."
Comment 3
Great example – here the patient might be thinking, why do I need this catheter when the problem is my leg?!
Comment 4
I'm always struck by patients who've been labeled "difficult" or "unpleasant" etc. can transform with a little TLC, information, or a combination of both. It doesn't always work, but it's a good reminder that, unless you are dealing with diagnosable personality disorders. People have a wide range of behavioral repertoires within them; and different events in the outside world tend to call forth different aspects of their personality.
Comment 5
this is one of those "simple" insights that nonetheless is very powerful. As you well know, explanations can be done well and badly. When an explanation is not tailored to the patient's questions and confusion, it becomes simply words. When it is an outgrowth of careful listening to the patient's concerns, it is empowering, and demonstrates respect and caring. It says, I want you to be my partner in your healthcare. It sounds as though in this case you delivered exactly the explanation that your patient needed; and the results were evident in his changed behavior.

F .10.AoD

2.8.10

Comment 1
Notice your language, Becky. "Grumpy" does mean difficult, but in kind of a (semi-) cute way. You are already framing this challenging pt in a way to help you cope appropriately, and not overreact. Nice!
Comment 2
How great that you were able to discover this "alternative" perspective of the pt. That's very important information – he's not a totally awful person, but only under certain circumstances (eg., feeling out of control, facing end of life etc.)
Comment 3

You are brilliant! Of course this is not easy to do, but this gives you a chance to move forward with this patient. Unless he's psychotic, is he really this angry about using the spirometer (although they are rather horrible!). Most likely he feels angry and out of control because he has several life-threatening illnesses, and the doctors that keep telling him to use the breathing machine can't save his life.

Comment 4

This sounds fantastic! I agree that by empathizing with his situation (no matter how unjustified his threat), you might have been able to defuse his rage and gotten closer to the root of what was making him so angry (and afraid, I'd wager).

Comment 5

You really showed insight and empathy in this essay - very well done! I'm sure anyone would have felt angry in this situation. The point is, what do you do next? Withdrawing is better than throwing your stethoscope at him (preemptive strike :-)). But it doesn't address what likely is really distressing the patient - as you discern, his fear of having a terminal condition which these doctors (who keep bugging him about using a stupid breathing machine) can't do a darn thing about. Granted, that doesn't give him the right to throw anything at you (and fortunately he did not), but probably what this patient needs is for someone to overlook his bad behavior and share some of his terror and fear. If you had responded in the way you proposed, there's a good chance that might have happened. It's VERY hard to do that in the moment, when the patient is behaving in a hostile manner. So don't beat yourself up - that is why we have whole lifetimes to learn how to be our best selves :-). But NEXT time, just give it a try. See what happens. Best, Dr. Shapiro

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M 6.11.AoD

1.31.11

Comment 1

This is a hard transition, isn't it? One day you're a medical student, next day you're an INTERN! (Remember this in a few months :-))

Comment 2

A bit intimidating I imagine – and yet you've got to like that it's original! (trying to keep a bit of a sense of humor in a tough situation)

Comment 3

I think you were able to see past his sarcasm and verbal aggressiveness, whereas the rest of the team was not.

Comment 4

Very often people mask their fear with anger, hostility, aggression. This is not right, of course, but if you understand this, you can often penetrate their superficial (unpleasant) veneer and get at what is really troubling them.

Comment 5

Oh my gosh, this is shocking! I imagine you must have felt terrible. Yet you were the only one listening to the patient and taking him seriously

Comment 6

Obviously I can't comment on the quality of the medical care, and you are likely quite right that medically the discharge of this patient was wholly justified. However, I agree with you that it is heartless to send away a patient fearful and alone without some act of caring and some f/u plan to provide reassurance (and appropriate medical monitoring). I suspect the outcome (i.e., the death of the pt) would have been the same; but he would have left the hospital on what turned out to be the last day of his life feeling that he was cared about and taken seriously. I understand that the pt himself did not make this

easy; nevertheless, it is what medical professionals owe ALL their pts, the sweet little old ladies and the foul-mouthed angry jerks.
Comment 7
Of course it's hard for me to say, but it seems to me as a new 3rd yr, you went out of your way to make sure the team heard your pt's fears. I wish they had responded more compassionately, even if would still have been discharged, but I think sadly there was probably little else you could have done.
Comment 8
What a sad lesson to absorb, yet it is very often what a busy inpatient service conveys to learners. I still don't think it is the RIGHT lesson.
Comment 9
As a non-physician and a patient myself, I sometimes find it upsetting how cavalierly physicians who don't know the patient at all can decide what is relevant or irrelevant to the patient's care! Although I understand the very demanding time pressures of inpatient care, I hope you will think carefully about the validity of this "lesson." Thank goodness Dr. Robitshek was still here to provide a corrective experience, and to show that the best medicine is patient-centered medicine; and that the patient's voice and concerns should ALWAYS have an important place at the table of patient care.
Comment 10
I was both distressed and moved by your essay. I find it very distressing when students conclude, based on the behavior of a physician or medical team, that the patient's voice and concerns are irrelevant to patient care. How absurd this is! Yet how easy to reach this conclusion based on practices that are too widespread in too many hospitals and clinics. Thank goodness you had the opportunity to work with Dr. Robitshek and have a role model who placed the patient front and center in his or her own care (what a radical concept!). As for your patient, I thank God that on what turned out to be the last day of his life, at least a third year medical student listened to him, took him seriously, and tried to advocate on his behalf. You should feel proud of your behavior that day, especially in the face of a team that had decided to write off this (admittedly difficult) patient. Even at that early stage in your clinical training, you were able to prioritize your patient; and you were able to distinguish between compassionate and indifferent patient care. I think ultimately you learned exactly the right lessons, and I am sure all your future patients will benefit because of it. Best, Dr. Shapiro p.s. I included additional comments in the text.

F 6.12.AoD
9.2.13
Comment 1
Great topic, ! This is so true – something we are all guilty of at times.
Comment 2
Ouch. This is very unprofessional. Even if the patient IS drug-seeking, this is an issue that should be discussed with colleagues in a professional, nonjudgmental manner, with a focus on problem-solving management.
Comment 3
No wonder! Such comments destroy any hope of a meaningful doctor-patient relationship.
Comment 4
Absolutely correct, it can be hard to figure out; and often, it is your third alternative – a combination of pain and manipulation.
Comment 5

you make an important distinction between outpatient and inpatient medicine. In an acute setting, you are not able to assess the situation over time and to put together the puzzle piece by piece.
Comment 6
An excellent insight. If you'd been among the group of trainees when Mary was described as "jonesing," how might that have affected your view of her the first time you walked into her room? She'd already

have 2 strikes against her! To me, it makes sense to use your best judgment in terms sorting out the murky aspects of treatment. Again, even if the patient IS drug-seeking, your role is to be respectful and professional, even while you set appropriate limits. But setting limits before you know what's going on may do a disservice to your patient.

Comment 7

You chose a valuable topic to reflect on. "Drug-seeking" vs. "real pain" vs some mixture of the two - it is very hard to sort out. One of the nice things about medicine is that doctors and patients are supposed to be on the same side until provem otherwise (I guess the medical variation of innocent till proven guilty). Sometimes you will make the wrong call, and feel your trust has been abused. Still, on the whole, I think it is better to believe the best about people rather than the worst; and sometimes you need to believe in a patient when they've stopped believing in themselves. Of course, this doesn't mean you should be naive or enabling about a problem as complex as substance abuse. But it does mean to listen carefully and nonjudgmentally as you try to piece together the story.

F 6.13.AoD

11.27.12

Comment 1

You are so right – there are many happy moments in medicine, but many sad and painful ones. Yet it is by "being the face" of medicine to patients and families that you can help prepare them even for the worst.

Comment 2

the process you went through sorting out your ethical responsibility to the family and your commitment to respect the attending is very impressive. This is exactly the kind of thoughtful reasoning needed in approaching these sensitive situations.

Comment 3

How wonderful! What a gift to you – an attending who could make space and be respectful of your perspective, especially as you were likely the team member who had unique insights into the family.

Comment 4

We sometimes think of the family as a monolithic entity, but this is often far from the case.

Comment 5

Very perceptive – you are exactly right. And the role of the physician is not to "side" with any one family faction, or make one faction into the "bad guys," but to try to get everyone's point of view on the table in a respectful and nonjudgmental manner. No wonder lots of docs dread family conferences. Yet they are a great opportunity to help a struggling family toward consensus and resolution.

Comment 6

I was so glad you had a chance to speak your peace. Students often end up understanding families (and patients) with more depth and insight than other members of the medical team, because they've spent more time with them. Your observation about black sheep and family dynamics was also perceptive – crises don't change family dynamics, they merely intensify them. Your job as a physician is to make sure everyone is heard and a course of action is settled on that is in the best interests of the patient. Sometimes very hard to do, but usually, with patience, possible.

M 7.10.AoD

2.8.10

Comment 1

Ouch, had this resident somehow misplaced his memories of what interview season can be like?!
Comment 2
This individual obviously had missed Communication 101. It is almost always better to approach people directly about concerns – and then pursue them with others only if it is impossible to achieve resolution one-on-one.
Comment 3

So you "followed the rules" – conformed to the protocol established to make these kinds of necessary absences as workable as possible for all concerned.

Comment 4

Unfortunately, this is a common passive-aggressive strategy; i.e., refusing to take responsibility for one's own feelings and implicating others inappropriately.

Comment 5
This should have been the responsibility of the resident; but since he wasn't able to do it, you are probably right such an interaction might have defused the situation, especially your explaining both the need for the absent days and your willingness to do additional work, even though it was not required
Comment 6

You know, you can always escalate – and sometimes this is quite appropriate – but it rarely hurts to start off on a more collaborative, let's-see-if-we-can't-work-together note.

Comment 7
Probably not, and since this may be a rather deeply rooted personality style, this might not be a realistic or necessary goal on your part.
Comment 8
Yes, I'd just add the qualifier "appropriately" deferential. It does seem as though his ego was stepped on (man, it must be rather large, it seems it was all over the place!). You didn't do anything wrong, so you had nothing to apologize for – but with someone who obviously takes things as personal attacks that have little or nothing to do with him, you might have helped him see that you in fact super-respected him and were willing to do whatever was reasonable to maintain a good working relationship over the course of the rotation

M 7.11.AoD
2.9.11
Comment 1
It seems that the irritation everyone felt made it difficult to have any empathy for this person.
Comment 2
It looks like you did make some effort to know her, but this did not increase your tolerance level
Comment 3
I do not think you were insincere by not telling her know how you felt.
Although the resident openly expressed his frustration with this person, was this a constructive way to deal with the situation?
Perhaps the stress of working on the wards made the team less patient and willing to think about what was really going on with this person.
For example, do you think she was trying really hard to impress because she hoped for a chance to do her internship at UCI?
Comment 4
I personally feel that it helps to ask oneself first:
1) is this the truth?

2) will I benefit or hurt the individual
3) will it make a difference to the situation at hand
I think the resident's comment was not really beneficial, and was hurtful, even though the rest of team felt transiently better.
Perhaps it would be better to take the person aside and tactfully try and understand where they were coming from, or leave well enough alone, and find ways not to feel as irritated!
Comment 5

Thank you. This is the greater principle that kept you civil. Perhaps we could include kindness too?
Comment 6
At the end of the day, knowing one truly did one's best, and that we are all human helps to see it in perspective. Thank you for this honest and thoughtful piece!

M 7.12.AoD
2.6.12
Comment 1
That close group of friends really does provide protection and groundedness.
Comment 2
So far so good, two guys letting off a little s
Comment 3
This is a very reasonable question. His lack of follow-up puts the onus on you to pursue the issue
Comment 4
Was it better to go through a mutual friend? Might you have approached "vomit" friend directly? If you had done so, might you have started from a position of inquiry, or curiosity? "Wow, friend, I haven't heard from you since that night. How're you doing? Feeling better? I wanted to let you know that the bill for cleaning up the mess was $300. " Pause, see what happens. If nothing, then "What are your thoughts about helping me out with this?"
Comment 5
At least eventually he did the (semi-) right thing, as I would think he'd step forward to pay for the ENTIRE bill, since it was entirely his responsibility
Comment 6
It sounds like you didn't find that excuse very satisfying. And no wonder, because it is less of a sincere apology and owning responsibility for a mistake, and more a justification. How could you pursue this? Could you share your perspective with vomit-friend? "You know, I understand how exhausting interviews are. But it hurts me that you weren't thinking about me as your friend." Then what he should say is, "I'm really sorry. I blew it. I will commit to doing better next time and I hope you can forgive me." Period
Comment 7
That is certainly one lesson you can learn. I wonder if another lesson is how to resolve situations that have gone wrong. It may be that vomit-friend is just kind of a jerk, and you don't want to be friends with him any longer because he is selfish and thoughtless. That's very reasonable. On the other hand, if it's a relationship that was meaningful to you, it may be worth the extra effort described above to clean it up. If vomit-friend continues to be defensive, unable to see your point of view, and dismisses the whole incident, then there's probably not much hope for a great relationship with this guy. However, if he realizes he behaved badly, and is repentant, he may deserve a second chance. Your call.
Comment 8
thanks for sharing what must have been a painful incident with this friend. It is so hard when people disappoint us, especially those in whom we've put our trust and confidence. I was really interested in what happened. I hope you don't mind that in my comments, I thought about different ways of interacting with your friend. To me, the main issue is has the guy proven himself to be a hopeless jerk, or did he

make a mistake for which he should apologize and get a second chance? Very hard to know. But despite the inevitable disappointments, as someone who also hopes for the best in people, faith in human nature (tempered by realism) is not a bad way to go through life. Best, Dr. Shapiro

Thank you for your essay. I am sorry you had this unfortunate incident with a close friend. It sounds as this has been weighing on your mind since it occurred. I'm glad you felt you were able to share it as this exercise is about difficult human interactions and I think some of these interactions occur with coworkers who have become close friends. I do not know your friend but from an outsider's perspective I am going to propose a possibility. Do you think your friend was just too mortified and embarrassed over what he did that he was afraid to approach you? He obviously handled it quite poorly but I can't help but wonder if he was at a complete loss of how to deal with this situation knowing that he potentially ruined your brand new car(!) as well as being embarrassed about not knowing how much alcohol is too much. After he did finally speak to you, it is unfortunate that he used such a lame excuse for not contacting you. You say you know this friend well. Is this something new for him or is there a pattern in your relationship that you see he is insensitive to others and self serving? If this is unusual for him and he has always been a quality friend who your really value, then I think talking to him about how you feel and preserving the friendship would be a good thing to consider. If you see he has always been like this and this was the "straw that broke the camel's back" then perhaps this incident was a good thing that opened your eyes that it is a friendship not worth saving and you may consider gradually backing away from him.

However, try not to let this incident and this guy's insensitivity cause you to generalize your feelings about all people and humanity as a whole. No one wants to be taken advantage of, and I think it is smart to be aware if this is happening too frequently but I think you should try to maintain your inclusive attitude to assume the best in most people as it will help to bring good people towards you and will aid you in making wise friendships as you move along your journey. Friendships do change over time and some come and go and it is an adjustment when this happens. Continue to surround yourself with friends who make you feel good. You sound like a good person Chris and I think you will ultimately handle this in a way that brings you peace.

M 7.13.AoD
11.29.12
Comment 1
Because medicine’s default mode is information, it is often a good idea to ask, what is the purpose of providing this information? How is it meaningful to the patient? Of course, information is power, and an informed patient is always in a stronger position. But it is also true that sometimes doctors inundate patients with information without helping them to see its relevance; and sometimes its relevance is extremely tangential to the concerns of the patient. The key, I think, is for the patient to be involved with the flow and nature of the information.
Comment 2
These were all great questions, because they are completely patient-centered. First you were not afraid to address the patient’s feelings. Next you ascertained what kind of information the patient wanted and would value.
Comment 3
I can imagine that you felt more than a little uncertain. It sounds like your attending felt you were ready to step up in this difficult situation – and as it turned out, you were!
Comment 4
In addition to your evident artistic skills, this is why the encounter was so effective, because you were working IN RESPONSE TO the patient’s desires.

Comment 5

this turned out to be such an interesting patient encounter. Most of us nonphysicians are surprisingly ignorant about the interiors of our own bodies, so I can imagine how illuminating this was for the patient. What I liked was how the information you provided was *patient-driven:* she had a sincere desire to understand exactly where in her body this cancer had attacked her – and you were able to explain this to her in a clear, accessible, and perhaps even beautiful way!

M 8.10.AoD
2.5.10

Comment 1

You felt not saying anything was too passive, did not address your feelings or do anything to improve the situation.

Comment 2

Of course, some things we should let go of, but I believe we should think carefully about this choice; and not make it out of fear or worry about the "hassle." Often we say we've let go of something, but it continues to eat away at us – a sure sign it needs to be addressed!

Comment 3

Again, since you were the injured party, it should be your decision to act or let go. It is true that, if nothing is said, the nurse has no opportunity to learn how her behavior affects others. However, it may well be, with this reputation that she doesn't care

Comment 4

Certainly if you had talked to her reactively and defensively in the moment, as you (quite understandably) felt. I wonder if there might have been a way to talk to this nurse calmly yet clearly about what a negative experience that was for you, and how it might have been handled more respectfully.

M 8.11.AoD

2.4.11

Comment 1
I respect your ability to realize that, no matter who the patient, this will be important in providing effective care.
Comment 2
Yes indeed. It reminds us that her difficult, angry, mood swing behavior is not entirely under voluntary control. You need to hold firm to your boundaries and limits with such a patient, but hold her actions with some lightness and compassion.
Comment 3

Unfortunately, you are right. It is asking a lot of stressed out, overworked residents to care for such an emotionally problematic patient. Nevertheless, there she is with her rotting leg, so someone needs to care for her. Take a breath and plunge in.
Comment 4
It's not a bad idea to have an exit plan. What's more painful from the patient's perspective is conveying (of course indirectly) that you are starting to implement your exit plan as soon as you enter the room!
Comment 5
What I hear in this sentence is a core, fundamental value for you. I respect that, upon reflection, you feel it could have been translated better into practice w/ Ms. B. God knows she sounds like she would challenge anyone's commitment to humanism. Still, in your description of that first encounter, you demonstrated that you were able to see past her Cluster B traits to the person beneath. Realizing that you are dealing with a personality disorder means that you have to accept that the relationship and human connection will have certain distortions and fissures. Knowing that, you can guard against them. I agree that even patients with personality disorders, who can drive us to distraction, deserve kindness, compassion – and boundaries!
Comment 6
A wonderful resolve, Sadly, almost no one likes these kinds of patients (not psychiatrists, not coworkers, not their family), but thinking about it from their perspective, how painful to be always avoided, dismissed, to constantly be on the receiving end of exasperation and annoyance. You could say they bring it on themselves, and long-term psychotherapy can make a small dent in these patterns, but basically they too a wrestling with a disorder that they cannot easily control. A team that acts with appropriate compassion and caring – as Dr. Koons would say, listening if not agreeing – actually has a better chance of delivering good care to this patient.
Comment 7
Absolutely. You express this very well. You don't need to be obnoxious, but you can model and encourage a different way of interacting with such a patient – one that is firm and clear, but that simply acknowledges the patient's humanity.
Comment 8
you chose a really great (in the sense of really difficult) situation to write about. Maintaining compassion and a sense of the patient's humanity with someone with Cluster B personality disorder (I remember learning this as the "erratic and dramatic") is one of life's real challenges. Yet it can - and morally, should - be done. I respect that you would try to be more present for a similar patient in the future (and then take yourself out for a hot fudge sundae or some well-deserved reward :-)). Especially commendable is your commitment to politely encourage future teams to not avoid, mock, or despise such patients. It is very easy (and understandable) for entire teams to fall into such patterns, and then everyone starts to think that's okay. Even though the definition of Cluster B personality types is that they push all our buttons and then some, we need to remember their disorder causes them a lot of suffering as well as us, and we need to hunt for their humanity and goodness under the rubble of borderline, narcissism, and histrionics. Thanks for a truly thoughtful and ethical essay. Dr. Shapiro

M 8.12.AoD

9.2.13

Comment 1
I'm struck that you really wanted to get to the bottom of the problem.
Comment 2
It is so hard to receive (and give – hence Steve's hesitation) critical feedback. Personally, I HATE to have my shortcomings pointed out! HOWEVER, if no one is honest enough with us to tells us these hard truths, we rarely learn since, as in your case, your perception was quite different.

Comment 3
What a great insight. “Bad” habits, inappropriate shortcuts can sneak up on us without our really being aware. It takes that little nudge, often from someone else, to realize what’s going on.
Comment 4
Aww, this is a nice ending. It is really amazing how often it’s the small things! Charles, I’m really impressed that you weren’t defensive, that you were willing to look at your own behavior, identify the problem, intervene with yourself, and come up with a solution that was not too taxing for you and obviously meant a great deal to the patient.

F.8.13 AoD
11.24.12
Comment 1
Haha, already I like this essay; and already I know it’s going to end up in a very different place than it began ☺
Comment 2
You are only being honest in acknowledging what almost everyone in that situation would be thinking – because it is such an easy way of pushing away a potentially scary, overwhelming patient.
Comment 3
Actually, this is a fascinating insight, and shows me that already you were starting to substitute curiosity for judgment.
Comment 4

And, as is almost always the case, once we start listening to the story, our judgments – and our fears – soften.
Comment 5

Again, I appreciate both your honesty, and your EFFORT to enter into a world so different from your own. It is true that such a frustrating and unsuccessful trajectory could wear away at even the most dedicated parents’ hope.
Comment 6
I’m filled with admiration at how your initial mocking attitude was quickly transformed into deep commitment and “compassion in action.”
Comment 7
Indeed, this situation sounds incredibly hard on so many levels.
Comment 8
I love that you call taking care of this patient “a privilege,” and that you recognize how much he taught you.
Comment 9
This is such a wise insight, How we treat others should not be contingent on outcomes, although it is understandable how we make these implicit “contracts.” But from a moral perspective, we might conclude that we “owe” others a certain respect and caring, regardless of whether such interaction produces “good outcomes.”
Comment 10

Buddhists talk about “seeing the flower the 500th time as the first time;” and it occurs to me that you are bringing that same freshness and presence to each patient encounter.
Comment 11
Exactly. Not everything in life works out perfectly; and if we judged everything by the ultimate outcome, life might often appear dismal. That’s why it’s important to pay attention to the “journey” as well as the “destination” – how we act toward each other in the process of getting to wherever, in a particular situation, we end up.

Comment 12
I loved its "narrative arc," the way it commenced with a bit of metaphoric eye-rolling and distancing, then progressed to commitment, presence, and continued efforts at understanding. Although like you I regretted that this story did not have a happy ending, in my view your conclusion was exactly the right one – it has to be about the process as well as the content. We can't always control how things turn out, but we want to feel we did the best we could in any given situation. In this case it certainly sounds as though you did.

F 9.10.AoD
2.3.10
Comment 1

It sounds like, for your patient's sake, you made many attempts to enlist this resident in the patient's care.

(Hmm, what is wrong with this picture?!)

Comment 2
Absolutely the right thing to do: expand the system. If the first resident was unresponsive after a reasonable effort, you have to go over his head.
Comment 3

It sounds to me that you made a real effort to communicate with the resident; then you communicated your concerns and needs to the Chief; then you chose to take on added responsibility for the sake of your patient. I'd say you handled this disappointing situation admirably – and not least of all did right by your patient!

Comment 4
I wonder if you believe that taking on greater responsibility and making greater effort is always the right choice. In this case, it worked out very well, both for the patient and for you (because you actually learned a lot – kind of like an informal sub-I!). Sometimes, however, it enables the offender; or forces you to pay too great a price. The important thing, as you did here, is to be solution-oriented and look for answers that prioritize the wellbeing of the patient; and of yourself.
Comment 5
I agree – how you behave under difficult circumstances is the measure of the person.

M 9.11.AoD
2.9.11
Comment 1
Thank you for sharing this poem…I really enjoyed reading it.
Comment 2
As a geriatrician, I love this line! It is good to keep an open mind, and not stereotype based on age.
Comment 3
this is a very thoughtful poem, and you have included a lot of great observations about the art of medicine.
I agree that the truth can damage the heart, and finding ways to still bring this truth, but with greater skill, is part of the "art"!
Comment 4
I think this is a positive and healthy attitude.
We are only human, and we continue to make blunders from time to time, but will learn the art if we make sure we are paying attention.

F 9.12.AoD
3.31.12
Comment 1
I appreciate that, although this was understandably an uncomfortable situation for you, you were able to understand where the family member was coming from, and his rationale for protecting his father.
Comment 2
This is a good question, but perhaps not asked at the best time. If asked earlier, then the team could have understood whether the father agreed with his son's protective role; or whether he felt he could handle bad news.
Comment 3
Yes, this seems like an awkward handling of a difficult situation. I wonder if the resident changed her mind and decided not to proceed until a family member could be present.
Comment 4
That seems doubly unfortunate., a real failure to follow through with a patient facing a terrible diagnosis and a distressed family.
Comment 5
As a medical student, I don't think there was much you could do. As you say, the real lessons will be those you carry forward to your own residency and beyond: 1) Clarify early on what your patient wants to know and who they want to be with them when they hear it 2) Don't raise patient/family member anxiety unnecessarily 3) Start what you finish – don't abandon your patient midstream.

F 9.13.AoD
11.28.12
Comment 1
This is where medicine requires so much courage – to say these unimaginably hard things in ways that they can be heard.
Comment 2
Sometimes these words are helpful to fill the space (although probably no one is listening anyway at this point); and sometimes these are moments where you too can be silent, as there is really no more information the family can absorb, and no words can "manage" the situation.
Comment 3
Yes, nice insight, "delivering bad news" is usually a process not a single actio
Comment 4
I admire that you took this plunge; and it sounds as though you handled it well; and also learned up close and personal just how hard this is – and yet too, how absolutely necessary.
Comment 5
I'm impressed that your attending had the confidence in you to allow you to run this meeting. It sounds incredibly difficult – yet, once sentence that stood out for me was when you said, the only people in the room who didn't know what was wrong with their child were the parents. They so needed this terrible information, and I deeply respect that you had the courage to tell them clearly and compassionately. I'm sure this is an experience that will always be with you. As you pointed out, silence can be the hardest – but also necessary – part of such an encounter. This was only one of many valuable lessons you learned.

M 10.10.AoD

Comment 1

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 2
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 3
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 4

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 5

I agree. This would merely have escalated an already tense encounter.

Comment 6

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 7
Outstanding, 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 8
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 9
Hi 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 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. Hope all is going well, and please know I'm sending good thoughts in your direction :-). Dr. Shapiro

F 10.11.AoD

9.2.13

Comment 1
I am not a physician, I don't know what "protocol" is in such a situation. But on a human, ethical, and by my ideas of what should be professional behavior, especially of an attending toward a student, this is truly TERRIBLE.
Comment 2
This seems like a very wrong situation to me which should have been handled differently. Of course, I don't understand the specifics of the surgery, but I know from other accounts of needle sticks that it is important to "bleed" and clean the area as quickly as possible. I would think that if the attending had taken responsibility for this situation, she would have figured out a way to excuse you and have the resident take over, at least as quickly as possible guaranteeing the safety of the patient.
Comment 3
This is completely unacceptable. I'm imagining that the attending was embarrassed to have been responsible for a needle stick (of her medical student no less!) and was essentially pretending it hadn't happened – especially in public. Her attention was likely on herself, and not on you, the one who had received injury.
Comment 4
Ouch, this must have felt awful, as if the whole experience was simply being dismissed.
Comment 5
This last comment is so telling, because it completely negates the previous rationalizations. If what the coordinator said at the start was correct, then you were in the wrong and there were no new "tricks" needed. This final comment suggests that the coordinator knew very well that this situation had been handled poorly, but did not want to approach the attending in question. This is an appalling example of the system covering up for itself..
Comment 6
Excellent point. In her comments, the coordinator completely overlooked the real issue that concerned you.
Comment 7
far from being too bold, you were speaking truth to power, which takes a lot of courage.
Comment 8
I can imagine how exhausted and drained you must have felt, as well as discouraged and hopeless. All that effort for apparently no effect.
Comment 9

So I assume this means she did not bring up the matter again, nor offer a sincere apology?

Comment 10
In fact, as you point out, you did not overreact; you followed proper procedure, as you had been instructed. In fact, it seems you were the ONLY one to do so.
Comment 11
And understandably so. The attending did not adhere to established OR protocol; worse, she did not exhibit caring or concern for her student; after the fact, she attempted to minize her wrongdoing.
Comment 12
This is always a difficult question to answer: how much and for how long do you fight? It takes time, energy, and often results (as it did for you) in ignoring or punishment. So you do have to weigh each situation carefully. But had you chosen to pursue it further (perhaps with Dr. Prislin, as dean of students) you would not have been "overreacting" by any means.

M 10.12.AoD

1.3.12

Comment 1
Nice distinction, this makes a lot of sense. Other factors may include the urgency of the situation, the underlying dynamics, and (of course) what is in the best interest of the patient. Giving a psych (or any other) paitent some sense of control may help with management down the road.
Comment 2
I wonder if you think your attending could have better prepared you for this encounter. Of course, it is possible s/he had not seen this more aggressive side of him
Comment 3

A very nicely turned phrase that contains an important distinction. Of course, the safety of learners, staff, and physicians is of paramount importance. No matter how disturbed, angry, or upset, nothing justifies behavior that jeopardizes others. In my view, such volatile situations should always be approached cautiously, with the least possible risk.
Comment 4

F 10.13.AoD
11.30.12
Comment 1
Great awareness and reading of nonverbal cues.
Comment 2
As you know, patients with Axis II, cluster B personality disorders can be very challenging
Comment 3
I'm not sure they took away her clipboard (at least she had it with her during the exam), but it seems like she was reading the nurses pretty accurately, which is the sad thing about "difficult" patients – they usually know they're disliked.
Comment 4
So understandable! It's a tribute to your patience that you started off by accommodating this desire for written communication.
Comment 5
This creates an extra burden for you. However, in the short-term, it might have been worth it, as these small gestures show that you are willing to care for the patient and don't "hate" her. With a borderline patient, of course, you need to remember that she might engaging in splitting between her "bad" nurses and (for a time) her wonderful medical student. But on the other hand, she might respond positively to someone who treats her with a little kindness. In my book, it's worth trying (and I've done exactly the same thing with a borderline patient who CLEARLY was testing me, but I wanted to demonstrate that if her demands weren't excessive, I wanted to help her out.
Comment 6
Again, this is so understandable, and how most people would feel in this time-pressured situation. One way to think about this is to ask yourself at the start, Am I honestly able to do what the patient asks? It is perfectly legitimate to say, After I've considered it, this is simply going to put me too far behind, and I'm going to have to ask the nurse. But if you decide, I think I can do these things, then it's the time to take a breath and get behind this decision full-heartedly. Easier than to say than to do ☺
Comment 7
And you know what? Sometimes situations DO get the better of us. Then all we can do is recognize that, as you did, forgive ourselves (and the person who caused us to topple), and try to be honest about our limits. I have been there MANY times.
Comment 8
These are such wonderful, thoughtful questions,. Sometimes it CAN be a chore to do just one more thing, no matter how insignificant. But sometimes it's because of the way we've framed it - "not my job").
Comment 9

And yes, we all have egos. A lot in medicine aggrandizes the physician's ego, and checking in to wonder on occasion, Why am I feeling this is beneath me, is worth asking. On the other hand, like you, at times I've seen physicians bring a blanket to a patient, or mop up vomit (not often I admit). So it's honestly assessing what you have the inner resources to do in a given situation, then put the ego issues aside and do it :-). Again, easier said...

Comment 10

Also such terrific thoughtful questions. They lie at the core of medicine. It might be worth actually noticing when service "fills you up" and when it depletes you. When we are scraping the bottom of that proverbial barrel, doing something kind for one more person can seem like a task, a burden. That's when it's time to ask for help from a higher power - or go for a run :-) It is really, really okay to say, I can't be my most giving, generous self today - then figure out how you can be tomorrow :-)

Comment 11

This may be where your own self-judgment is a little harsh. You have so much compassion for others, extend a bit of this to yourself. Don't be afraid to nourish yourself, that is how you will have enough to give to thers.

Comment 12

I think a spiritual orientation can help (a lot), but at least in my experience it is no inoculation. Guess why? We're human. We need to learn when to take a pause, to admit I'm at the end of my capacity, not with hatred, but with love... and give ourselves permission to replenish.

Comment 13

I feel so privileged to have read your reflections about this encounter. You are amazingly self-aware and perceptive. I apologize, I could not stop myself from making lengthy comments in response, but only because I was so engaged by the questions you were asking and the soul-searching you were conducting. I'm super-impressed. I won't add to my logorrhea here, but I do want to say that the key (in my view) is awareness and discrimination (what did I do? Might I be able to do it a little better next time around?) but not harsh self-judgment (I'm a terrible person because of my thoughts when I brought my patient a blanket). Otherwise the self-flagellation may distract you from the main goal, which is to understand more deeply (which you certainly do) and try again (which you certainly will). It was an honor to read this.

F 11.10.AoD
2.14.10

Comment 1

Indeed, this is a "wonderful" example of what seems like a simple agenda to the dr being perceived as onerous, unworkable, and indeed impossible to the pt.

Comment 2

Neither of your approaches – education, persuasion – were bad choices, but your pt exercised the great power of NO!

Comment 3

Ah, sometimes the best response to our own frustration is curiosity. Not, "how irresponsible she is," rather "how did she come to this decision? what's going on?" This can help you evaluate the situation without so much judgment.

Comment 4

Isn't it amazing that when we better understand the other, often we move spontaneously from critical judgment to empathy.

Comment 5

Ah, you are willing to put yourself in the patient's shoes, and realize that, from her perspective, this is neither "simple" nor "easy"; and who knows how well you'd be coping facing the same challenges?

Comment 6
Great job, You challenged your own initial judgments about the pt; returned to her bedside to "learn more"; revised your opinion of her situation; and sought to get her help. This is a wonderful example of true empathy!

F 11.11.AoD
9.2.13

Comment 1
Yes indeed, it is not only the doctor and the patient who may have different perspectives; each family member brings their own unique point of view and life experience to what is already a deeply emotionally fraught situation.
Comment 2
This is so incredibly wise, it shows me what a wonderful doctor you will be. It takes a great humility to recognize that, even though you're a doctor, you may not be the most important person in the room; and what you know may not be what matters most.
Comment 3
It takes a deep commitment to the wellbeing of patient and family to sometimes just sit and listen.
Comment 4
Although you could not comprehend the language, it is obvious how involved and present you were during this family conference.
Comment 5
Having the capacity to "step to the side," to be present as a resource and a support, but without needing to micro-manage how events unfold shows a confident, compassionate, and discerning physician, who can make a space for true healing to occur for everyone involved in the end-of-life process.

F 11.12. AoD
2.6.12
Comment 1
It is unfortunately so true that, for most of us, the more exhausted we get and the more energy we expend just managing a situation, the harder it is to find empathy. I can relate!
Comment 2

I wonder if this was because there was no context for this extended effort. A lot of time was spent, but there seemed there was no coordinated plan or intervention.
Comment 3
You weren't included in this part of the story, to your educational detriment. If the patient indeed was suicidal, then you might have felt that the time you spent with her had a purpose. On the other hand, the on-call resident may simply have been taking the easy way out (it's hard to imagine that a good night's sleep solved true suicidal ideation!). Perhaps you felt that your learning had been compromised, and instead your time was spent as a babysitter. There were a lot of sources of frustration!
Comment 4
Psychiatry involves a lot of uncertainty, and it's hard to know whether this was simply an out of control teen and an overwhelmed mom, or something more serious. As the medical student, you were left out of the equation, and this may have affected your attitude toward the patient. In your telling, you seem reduced to a babysitter role; and it was unclear what happened to convince the on-call resident that a 5150 was the appropriate course of action. I hope you've had other opportunities during your training to learn

more about 5150. It is never a step to be taken lightly; but obviously when utilized properly, it is an important physician tool in protecting self-destructive patients from their own impulses. Thanks for sharing your thoughts, Dr. Shapiro

11.25.12
Comment 1
Ain't it the truth. I hope someday someone does a study to explain why this happens! :-)
Comment 2
Haha. I appreciate your awareness that we mostly have some ego investment in our work, even when it involves service to others. Not a bad thing, but good to be aware of it.
Comment 3
what a profound and tragic comment. I think you see exactly where the communication "barriers" lie.
Comment 4
What a helpless feeling this must have been for you. The end of life conversation has to be had. The family is not ready to let the patient go. The medical student cannot help the patient's pain. What a distressing set of circumstances.
Comment 5
This sounds shocking, although you are right to recognize that there may have been a misunderstanding between the team and distraught family members.
Comment 6
Of course I was not there, and I have little right to comment. Yet I always wonder at the statement, "There was nothing I could do." It certainly sounds true that there were many things you - and the team - could not do: you could not save her life, you could not cure her cancer, you could not even delay its progression, you could not even drain her pleural effusion, you could not persuade the parents that she was dying, perhaps you could not even adequately provide pain control. I wonder if there was any comfort or understanding you could give to her and her family, perhaps by listening to their hopes and helping them adjust these hopes. Perhaps this was not possible, and then all you can do is show up, be present, be caring, and support the patient in her dying.
Comment 7
It may not have been reassuring to the parents, but I wonder if there was some sense of relief that at least their daughter's suffering was mitigated
Comment 8
this was such a hard essay to read, I probably cannot fully imagine what it was like to actually live it. I found myself looking for silver linings, and sometimes there is no silver line. The patient is not ready, the family is not ready, no one can communicate, there is a lot of pain and suffering. I could feel your helplessness and frustration. I believe (personal view only) that in these circumstances the only role remaining is that of compassionate witness – and that is a hard role indeed. Nevertheless, I very much appreciated your sharing about this patient, perhaps it made the burden a bit less (silver lining search?)

M 12.10.AoD
2.3.10
Comment 1

You are stuck in the middle between a patient quite possibly in pain and very definitely seeking drugs, and a resident who's decided this is a "drug-seeking pt" and has washed his hands of the situation.

Comment 2
This is so completely understandable. Who likes to be lied to?! However, once you know that you are encountering a patient who wants drugs, it almost goes with the territory, doesn't it? The pt will attempt to lie and manipulate because his/her need for drugs is stronger than his/her respect, caring for you as a doctor or a person. As you become more experienced (as no doubt you already have), you can identify drug-seeking behavior, and without caving into it, you also don't have to be unduly upset by it either.
Comment 3
I admire that you were willing to stay committed to this patient's care, even as he behaved in an emotionally abusive, angry manner. This is a situation in which the therapeutic relationship is unbalanced – you still have to care about this patient even though he doesn't care about you.
Comment 4
Oh no! Perhaps it's not irrevocably ruined, but just tarnished a bit!

F 12.11 AoD
1.28.11
Comment 1
Sometimes, when we want to ignore a difficult situation, we pretend (to ourselves) that it's trivial ("laughing it off") but if we were more honest, we'd admit that our feelings were hurt and the other person behaved in an insensitive manner.
Comment 2
Absolutely, this is an important distinction. All of us need to be open to receiving feedback – but how feedback is delivered matters. People should always strive to communicate in respectful, empathetic ways, even when they are conveying a constructive criticism. Demeaning the other is never a good teaching strategy.
Comment 3
Well said. When people's feelings are hurt, they tend to be defensive, which reduces their capacity to learn and change. Making criticism about behavior, rather than about the person, helps to give a little distance.

M 12.12.AoD
3.2.12
Comment 1
I find it fascinating – and disturbing – that there often seems to be no way in medicine to talk about the loss of a patient. I don't think it needs to take hours, but the total lack of acknowledgment is hard to understood. Further, although the intern was clearly upset, there was no way for her to share her distress or process her grief. Different teams handle codes differently, but I wonder what your thoughts might be about other possible approaches.
Comment 2
Again, to me sad and troubling. You had the skill to give her an action opportunity that might have helped both you and her, but she shut it down quickly with the message that the correct response was to "tough it out" and NOT talk about it.
Comment 3
Once again, from my perspective I think this is more excuse than reality. You don't need hours and hours of processing (although with "first deaths" I think there should be a mandatory session where students and interns have the opportunity to talk about their reactions and concerns with other more experienced clinicians (who haven't shut off completely to the human side of death). But a minute to acknowledge the death, a minute to console the family and to support the team would be time very well spent!
Comment 4

Very well said. Efficiency is a value in clinical medicine, and that's not a bad thing. But it shouldn't be the primary value, especially in such an emotionally fraught situation. Also, I reject the contention that acknowledgment of grief or sadness at the death of a patient is "inefficient." You are correct, it is much better understood as a cultural perception.

Comment 5

I am so very glad to hear this. You are already a part of this culture, and as you progress up the food chain, you will increasingly be a role model and "culture maker" for and with others. Trust your instincts – you are right on this one!

Comment 6

I very much agree. Physicians who regard the death of a patient as merely a task to get through will carry this attitude of objectification into other patient and family interactions as well. Both patients and physicians are harmed by the loss of physician humanity.

F 12.13. AoD
12.2.12

Comment1

I can certainly understand the reaction of your classmates; but your perspective why this will be a rewarding subspecialty for you.

Comment 2

how wonderful for this young and alone mom that you were willing to share in her joy when her baby smiled and for once did not appear suffering.

Comment 3

Thank goodness you had such a skilled attending. As you describe, accurate understanding is key, as is giving the family a sense of control in a very out-of-control situation. Finally, giving emotional permission for parents to choose palliative care in a way that does not make them feel like "bad" parents is an art. A role model like this demonstrates that, although we all feel like there is nothing we can do to help, in fact there is a great deal.

Comment 4

People's resilience and grace in even the most terrible of situations is truly uplifting.

Comment 5

You attending embodied "compassion-in-action," taking active steps to express her concern and caring for this family's situation.

Comment 6

Your initial feelings are so completely understandable, Jasmin. Yet whether or not you chose to share in a small way in the family's grief, they would still have had to endure their own sadness and hopelessness. I think one thing you, your attending, and the team was able to do was to ensure that they did not go through this experience on their own.

Comment 7

Thank you for this perceptive essay. I particularly liked what you wrote about your classmates' views of pediatric neurology vs. your own. The way I look at is that these families are suffering often very difficult and painful events; the only question is, who will be there with them? If you can find aspects of such situations that are inspiriting, valuable, and of service, then you will not experience such tragic outcomes as devastating, although they are of course terrible, but you will feel, as you wrote, that you and your medical team were there to support, guide, and counsel the families in this moment of great need. I made a few additional comments in the text.

M 13.10 AoD
2.10.10
Comment 1
You know, this is a profound observation that has never occurred to me (not ever being in that situation myself). If a pt becomes DNR and then codes, there is no real "protocol" – it's just business as usual until the pt expires. I wonder whether there shouldn't be some ritual for the team that acknowledges the passing of the pt.
Comment 2
This is indeed a hard thing to acknowledge. Maybe it is not the ONLY "true reality" but it is certainly a very evident "true reality."
Comment 3
As we talked about yesterday in class, words matter. No wonder doctors don't like to "do nothing," "give up." These sound so passive and helpless. I wonder what would happen if we started talking about "letting go," "accepting the pt's passing"!
Comment 4
This is such an important insight, Medicine does some amazing things for sure, but it is imperfect and limited. That's nothing to be ashamed of, but this aspect must be integrated along with all the triumphs, otherwise doctors will have a distorted view of what it means to practice medicine.
Comment 5
Wow, I LOVE what you say here. That's amazing. There is so much in medicine that tries to differentiate doctors from patients (beginning with the fact that some [the lucky ones] are "doctors," while the others are "patients"!). But at core, all of us are in this life together, leaning on each other, trying to live the best we can. I think if you can keep this perspective in mind, you will never succumb to the arrogance that besets too many physicians.
Comment 6
Indeed, I think this speaks to the interdependence and connectedness of all beings.
Comment 7
This is simply eloquent and very beautiful indeed. I can't add anything, you have said it all.

F 13.11 AoD
2.11.11

Comment1
From what I've heard from students on this issue, this is not a prevalent response. Still it's got to feel hurtful and frustrating.
Comment 2
Good for you for persisting both in visiting this pt and in trying to ease her suffering.
Comment 3
Ouch, this is awful. I would be telling myself that perhaps part of this hostility was due to the pt's axis II disorder.
Comment 4
I commend you for admitting this reaction. None of us likes to think we are ever "spiteful" in the way we behave toward a pt – but of course we are (and angry, or condescending, or annoyed. Or demeaning, or something). That's because we are not always in complete control of our emotions. You endured mistreatment and emotional abuse from the pt for over a week. It is not the response we hope for, but no wonder your "spite" leaked out in this nonverbal action (or non-action :-)>
Comment 5
Ah, now you're clicking. Be curious, not furious! What is driving this pt's behavior? How much of it is BPD? How much of it is a previous bad experience with a med student? Understanding does not mean

acquiescence, but it will soften your emotional reaction, and may also give you insights into how best to approach the patient.
Comment 6
That's a beautiful "protocol" to follow. I respect that you've developed additional emotional regulation skills to deal with these admittedly aggravating patient care situations. And I'd just point out that experience alone doesn't necessarily make you wiser, so you've done a great job in figuring out some of your emotional triggers, and counteracting them with empathy for the pt

M 13.12 AoD
2.15.12
Comment 1
This is a good example of a systems problem, in which exhaustion and overwork makes decent people behave badly. It's worth asking yourself, what will prevent me from being this resident next year?!
Comment 2
Long hours and burden are explanations, but NOT an excuse. Outbursts and abrasiveness toward colleagues, staff, and especially those more vulnerable, such as medical students and patients, is unacceptable.
Comment 3
Excellent, . You have to choose your battles, and sometimes ignoring or "floating above" an issue is a very reasonable strategy. However, it is also true that, handled skillfully, "discussing" an issue with someone else doesn't have to be a battle, but more of a learning experience. Business leaders know this as a way of DEFLATING conflict, and I'm glad you've learned it as well.
Comment4
Important qualities – rather than an ad hominem approach ("You're a mean resident") you focus on both positive and negative specific s. This will help the resident put her issues with you in a positive context (what's working), while helping you see how "what's not working" can be remedied.
Comment 5
Thank you for sharing your essay with me. I guess the theme and point of revisiting and writing about these difficult encounters is to work on our communication skills, including confronting a difficult superior in a professional manner. I think we have all had the experience of dealing with a supervising resident or attending who has some personality disorder making them scary to approach. In your situation you were obviously uncomfortable with confronting this particularly abrasive resident. I can't help but wonder what was going on in her life, to make her so abrasive in addition to being overworked. Sometimes if you find out what that person is dealing with, it can help you empathize with them and make them seem more human and more approachable. Another essay I read mentioned the abrasive attending was dealing with a malpractice lawsuit and knowing that allowed the victim of that attending's overreactions to at least understand where her hostility was coming from. In terms of confronting someone who doesn't seem to like me, I can empathize with you, in that I will often want to run and avoid that person at all costs rather than attempt a direct conversation with them. I think the wording ("what's working and what's not working) you learned from the business school were really good ones to open up an effective professional dialogue. I agree it is important to make sure, as you mentioned, that your supervisor knows that you are at least making every effort to improve and put your best foot forward. Leave it to the business folks to know how to handle difficult people. l guess the key is keeping the interaction brief, to the point and non personal. Still, it is a skill many of us, including myself, could use some practice. I'm glad you feel you have gained the inner confidence to communicate in a more direct and active way in the future. I think you will find having success at this will bring you a lot of satisfaction in your abilities as you move forward in your career and even in your personal relationships.

F 13.13 AoD

11.29.12

Comment 1
I wonder how this made you feel – were you embarrassed, angry, self-conscious? Amused?
Comment 2
Well, at least he's demonstrating he understands a lot about hospital hierarchy! ☺
Comment 3
Wow, really? Good for you – you did not let a chilly reception dampen your interest in learning from this patient.
Comment 4
Oh, you are sly! But honestly, this was a terrifically creative approach. I'm very admiring.
Comment 5
I wonder why. Might it have had something to do with the way you skillfully altered the power dynamic and restored some control to a person who, after all he'd been through, must be feeling tremendously OUT of control?
Comment 6
you've impressed me as someone who always learns something from her patients. You bring a wonderful combination of humility and curiosity to the encounters (that I've heard about) that will make you an outstanding physician.
Comment 7

What a great approach to explicitly define your role in relation to the patient. I hope all students would see themselves as patient advocates.

Comment 8

A very good observation. It is very easy to lose touch with the patient perspective. The good news is, if you continue to practice this perspective-shifting, it will become second nature to you (I suspect it may be already).

Comment 9

Another good insight – when people are ill, you are usually not seeing them at their best. It doesn't excuse bad behavior, but it can soften our judgment.

Comment 10

I love it when, at the end of a difficult encounter, you can say, "I am thankful." "Difficult" patients and people truly can be our teachers if we are ready to learn. And as you say, that learning can benefit future interactions.

Comment 11
I am very admiring of your persistence, interest in, and creativity toward this patient. Through ingenious and compassionate approaches, you won him over and became his ally rather than his enemy. So well done!

14.11. AoD

1.26.11

Comment 1

Does your sister have kids of her own? What is your relationship with her generally like? These are questions not to answer to me, but to ask yourself to better understand what she is asking. Does she

just want to be more involved with your baby? Does she see the baby as a way to get closer to you? Is there any competition in the relationship?

Comment 2

You are juggling an awful lot, Emily, which means that you need to be really clear on your priorities. Sibs are important, of course, but probably higher up comes your relationship with your son, with your husband, caring for yourself etc.

Comment 3

It sounds like your sister was trying to get what she wanted – more contact – and knowing how much you're dealing with, went after your husband. Not a great strategy, but sometimes it's hard to accept that EVERYONE in a family system is doing the best they can, even if the result is not exactly what we hope for.

Comment 4

When people say, you can make different choices, it can sound as though you are choosing "against" what they want. If you think about it in terms of honoring commitments (to your son, your husband, yourself, your work), it puts a different frame on things. Is your sister seriously suggesting you should abandon your medical career? It makes me wonder about the choices she has made in her life, and whether she is happy in herself with her "choices."

Comment 5

This was probably a very wise choice. When things escalate interpersonally, sometimes the best action is to withdraw (temporarily) to let the dust settle. However, it is important to return to the fray from a calmer place, because time alone does not necessarily heal these kinds of rifts

Comment 6

These are ALWAYS good approaches. Try to understand what your sister is saying. What does she want? What does she need? What is she afraid of? Maybe she is just sad that she feels she is losing touch with you. Maybe there are other issues she's bringing to the table. The most important thing is to clarify and listen, so you really grasp her point of view. You don't have to AGREE with her, or do what she wants; but she will feel much more heard and cared about if you start off doing these two things.

Comment 7

Yes, this would be one way to acknowledge that you care about what your sister is asking (again, it has to be realistic and manageable for you – you have a right to set your own priorities as above, so you need to negotiate something that is not too burdensome for you).

Comment 8

Ah, this is so insightful, Emily. In most conflicts, both people usually bring stuff to the table. You are so wise to realize that you reverberated so strongly to your sister IN PART because her less-than-skillful comments nevertheless played into your own doubts and fears. The questions you've been asking yourself all of a sudden were coming out of your sister's mouth, in a rather harsh and accusatory way. No wonder you were so upset.

Comment 9

Thank goodness for iphones! :-). Seriously though, it is NOT just about that first step, it is about all the steps that follow, and you will certainly be there for a good many of those.

Comment 10

Absolutely. When you are able to resolve your own doubts and trust that you are making good choices for yourself, your son, and your family, you will be able to respond to your sister (or others) from a more centered place. You can acknowledge that these are difficult decisions, that you've tried to think them through very carefully and honestly, and you think that for now the path you've chosen is right for you and your family.

Comment 11

Yes. Indeed. Although I would never minimize the challenges of being a new mom and a new doctor, plenty of doctors have children, and most of these children are happy, well-adjusted, and proud of their parents. Far from hurting your son, you are showing him that it is important to care not only about one's family, but about the larger world. Personally, I can't think of a better lesson to impart.

M 13.12.AoD
4.3.12

Comment 1

It sounds as though the team was thorough and conscientious.

Comment 2
thank you for your honesty in acknowledging this lapse. I went down exactly the same path as you and your team as I read the essay. It is understandable to work with the information you have, but how easy it is to make quick judgments based on limited knowledge. What impresses me, however, is that you didn't attempt to rationalize or defend, but quickly felt "deep regret."
Comment 3
Perhaps. It's impossible to know in this particular case; but as a general rule, it is true that assumptions about patients can lead to ignoring other evidence. Jerome Groopman writes about this phenomenon in his book How Doctors Think.
Comment 4
as always, I respect your genuineness, your nondefensive attitude, and your willingness to learn from mistakes. You won't be able to be a perfect doctor, but these qualities will help ensure that you minimize any harm you inadvertently cause. One really uplifting aspect of this story is how the whole team "spent a long time" talking with the patient, as a form of compensation for their earlier judgments. Fortunately, especially in the psychosocial realm, you usually have plenty of opportunity to correct your errors.

F 13.13 AoD
9.2.13

Comment 1
It's a good insight, , that when people are frightened, helpless, or out of control, they tend to attack the nearest person available, who may well be an innocent doctor (or med student!).
Comment 2
I'm very impressed at how you managed to get this 18 year old to open up and tell his horrific story. As you well know, adolescents are not known for their willingness to disclose messy situations. You must have been a safe and trustworthy listener.
Comment 3
These were both excellent approaches – caring, and then offering a mediation session.
Comment 4

There is probably little else you could do. In a comprehensive PCMH setting, you could extend counseling services to the patient and his father, which is probably what is needed most.
Comment 5
If the patient could afford this, and if he followed through (two big ifs!), this would be an excellent intervention. However, even with a primary counselor, there is an important role for the primary care physician, to monitor the young man's safety, physical and emotional health, and hopefully progress; and to offer ongoing encouragement and a listening ear. Both provide real therapeutic benefit, so they are not "nothing."
Comment 6
It is natural to want to do more, but honestly (other than the possibly unrealistic nature of the referral), this was handled pretty well. Remember that you played a crucial role in shifting the conversation from "cold" to the root issue, which then could be addressed. I understand your disappointment, and sense of helplessness, but you should be willing to pat yourself on the back a bit for helping this patient recognize where the true problem lay.
Comment 7
I can see why this patient and his situation stuck in your mind. His youth, his vulnerability, the fact that he opened up to you would understandably pull at your heartstrings. Nevertheless, as you can see from the comments I made in the text, I thought you did quite a lot for this young man, notably helping him to define the underlying problem and to recognize that he needed additional support from a third party. Appreciate the sharing, and let's both say a little prayer that things worked out well for him

F 15.10.AOD
2.1.10

Comment 1
Ouch! And just when you were ready to "waltz" to freedom! Talk about the proverbial straw.
Comment 2
You might have been seeking information, but "why" questions often come across as accusations.
Comment 3
Yes, it's important to pay attention to tone of voice because it conveys so much. Even when our words are nice, when our tone is mean, that's what will be remembered.
Comment 4
So hard to do, but so helpful when we can actually pull it off. With a little more sleep and a little less emotional arousal, you might have decided on a slightly different approach.
Comment 5
This is really a good point Jennifer. I think you just "seized the moment," but by having this confrontation in a public forum, especially in fron of "her" people, the head nurse probably became invested in proving she was "right" and had not acted inappropriately.

M 15.11. AoD
2.11.12
Comment 1
Sadly, there are more than a few people like this in the world!
Comment 2

Yes, I was wondering why apparently positive qualities grated, but sincerity is the key. As you well know from pt care, you cannot successfully “fake” kindness or caring or interest. Pts sense the lack of genuineness.

Comment 3
I wonder how you might assess this “feedback.” It seems rather harsh and unhelpful to me. It is one thing to have the concern that someone is insincere, but lots of people have less than beauteous laughs. In my view, when people annoy us, it’s important to figure out a) how serious it is (eg., does it affect the team functioning? Is it detrimental to pt care?) and b) whether it’s something the person can change (e.g., poor listener, always interrupting, laughing inappropriately).
Comment 4
Ouch. It sounds like because of irritating personal qualities, she become the “outsider” of the group. You were all united in disliking her, which was good for group solidarity but perhaps hard for her.
Comment 5
It’s not always possible to get to the bottom of our likes and dislikes (although it’s worth a try, to try to understand them better, and see if they are justified). I’m still intrigued by the “insincerity,” I would want to try to understand that better. Sometimes, for no “good” reason (i.e., bad doctor) we might not like someone. I think this is okay. To me, the real question is what we do with our dislike. Is it a fair dislike? Does the person deserve to be treated badly because we don’t like them? It depends, of course, but in situations where we can’t just avoid the person (i.e., work, or family) it’s probably useful to think if there are behaviors or attitudes the person could change to be less annoying. It also might be worthwhile to see if there are other aspects of the person that are more likable or admirable, so that your view isn’t too slanted (as you pointed out, “she wasn’t lazy, she wasn’t mean to patients…”
Comment 6
See, this is what I’m talking about. You didn’t “like” her, but you tried to act in a reasonable , kind manner, which I’m sure on this team she appreciated.
Comment 7
Interesting that insincerity comes up again. Perhaps she wasn’t the only insincere person?
Comment 8
This is a really interesting question. I don’t know the answer. It seems to me telling someone they are annoying because of the way they look, or the way they laugh, or because of a personality quirk that would seem very hard to alter is kind of pointlessly cruel. You might have said, a la Meyer Briggs (remember that session?), "Our personalities don't mesh easily. I'm more straightforward, introverted (whatever) and you're very bubbly, extroverted (framing her qualities as positively as possible). I don't want that to get in the way of our working together, and I'll try on my end, and maybe you can try on yours." If the person has identifiable behaviors that demonstrate poor communication, thoughtlessness etc., these I think can be worth bringing to someone's attention.
Comment 9
Pretending is always exhausting and not very effective. Perhaps another strategy would be to work with your own feelings. Owning your annoyance is honest. But perhaps by focusing daily on all her annoying attributes, it just solidified this story. I’m not saying you could ever be good friends :-) but maybe if you'd chosen to "soften" your annoyance by finding something to appreciate in her each day, or something you admired, or something you thought was reasonably decent, you might have been able to have a more balanced view of this person.
Comment 10

In contrast to your senior, who I believe gave vent to his feelings in an unprofessional manner, you conducted yourself with politeness and civility. That is the professional choice, and given that you were overcoming equal dislike and annoyance, I think you should be quite proud of how you behaved.

M 15. 12 AoD
2.3.15
Comment 1

Very interesting. An example of the lowest on the hierarchy coming together to pool therir limited power for the welfare of the group.

Comment 2
With all the social and informational media available, cheating is a HUGE problem. It is not a trivial defect. And it seems to me this is especially true for a future physician. Even though the pressures are great on fellow students to look the other way, this seems wrong to me.
Comment 3
Reflecting socratically on this dilemma is appropriate; as hindsight can never fully answer what we should have done in any given situation. Your questions are excellent, especially the one about whether this represented a pattern for this student. If that was the case, then the pattern probably developed because no one was willing to interrupt the cheating behavior.

It is always difficult to know when to intervene in another's bad behavior; and whether to do so personally or by bringing it to the attention of someone higher-up. Of course, you have to choose your battles; no one appointed you the moral police! However, I always think that, when we see wrong doing and turn away, we become complicit. I've averted my eyes many times in my life – but most times I've regretted it. You, on the other hand, did not turn away – you moved aside so that you would not be a "shield." I see that as a moral act, and who knows, maybe it was commensurate with the moral violation being committed. There is no clear answer to that one!

M 15.13 AoD
12.2.12
Comment 1
Ha! Very true, especially in the peds "mythology.".
Comment 2
I agree. Parents can act in crazy ways sometimes, but it is usually out of a desperate fear, guilt, and helplessness. Once you understand this, it makes the "difficulties" they pose much easier to deal with
Comment 3
Excellent observation. This may have been a situation where the team colluded with the demands of hard-to-manage parents at the expense of the patient's wellbeing. Hard to know of course, but it is important not to confuse empathy with acquiescence to inappropriate behavior.
Comment 4
This behavior, while understandable, is unproductive, and as you illustrated above, may have jeopardized optimal treatment of the patient. Sometimes it helps to "surface" the dynamics, to gently confront the family. "I know how scary this is, and how hard you're fighting for your kid. We understand that and respect that. But when you attack us, it makes it hard for us to do our job. We too want to do the best job we can to care for your kid. How can we work together to ensure that happens?" This type of approach sometimes shows the parents that their behavior is undermining exactly what they want to achieve.
Comment 5
Good for you,. It can be really easy for a busy physician (or medical student) to avoid parents like this. Instead, you made the choice to give them attention, make sure their (appropriate) needs and concerns were being addressed, and generally conveying the message that they and their kid were important to the hospital. Absolutely a wonderful choice on your (and the team's) part.
Comment 6

Oh sweet irony. To me, this shows that so often, this behavior is not personal so much as randomly targeting the nearest object on which to vent fear, frustration, and anger.
Comment 7
what a lovely essay this is. It shows your insight, empathy, and willingness to do the right thing (even when it is not the easiest or most comfortable thing). Your analysis of what was driving these parents of the FTT child seemed very sound to me. I admired your decision to check in regularly with the parents (rather than avoiding them), thus reassuring them that you (and the team) actually cared about them and their kid. The fact that in the end trust had been established and they actually chose as their pediatrician the doctor whom they had yelled at in the hospital says that often patience, persistence, and just staying engaged will carry the day. Thanks for sharing this happy-outcome story

M 16.AoD
2.16.10

Comment 1
Good for you. There are always a million reasons NOT to return – i.e., paperwork, labs to check, pts who WANT your help etc.
Comment 2

These are wonderful, nondefensive questions, Jerry. You come from a place of compassionate curiosity… help me understand how we can do better.

Comment 3
This may or may not be a "legitimate" complaint, but it is very important to understand that this is the patient's perception.
Comment 4

I would say you were very accommodating! This is the "servant" role of the (student)-physician – but perhaps it conveyed that you were not too proud to help her with even the most mundane and personal tasks.

Comment 5

I find this very admirable. It would have been so easy, after all the above effort, to have been frustrated and annoyed that your pt did not "try harder," or was unable to accomplish more. Instead, you were able to appreciate (literally) "baby steps."

Comment 6

And this is entirely appropriate. As a former mentor used to say, "You have to know how to get into [the pt's] boat… and you have to know how to get out of it."

Comment 7
you are being very sensitive to the potentially multiple causes of this pt's pain. I agree, she does not sound as though she was "drug-seeking." Perhaps, as you speculate, some of her pain might have come from the feeling that "no one here ever listens to you," an issue you addressed very well through expression compassion and empathy for her suffering (both organic and functional).
Comment 8
Excellent observation. Although this was a very difficult experience for the patient, perhaps she benefitted both from the positive attention and the "cheerleading."
Comment 9

Excellent insight. After all, fundamentally the whole process of diagnosis and treatment is all about the patient (although that sometimes can be overlooked), so naturally they want to be involved :-)
Comment 10
Sometimes you might have done a "good job," but it just didn't get through to the pt (kind of the key part!). So it can be appropriate to be self-evaluative ("my communication skills suck") so that you recognize and can improve upon mistakes; but another approach is to simply notice ("that interaction didn't work; let me try it a different way"), which is less about allocating blame, and more about paying attention and continuing to try out different ideas.
Comment 11
Brilliant. This might seem "irrelevant," or "inefficient," but if you take the long view, it can actually save time because the pt starts to feel heard, seen, "known," therefore starts to trust you and work with you.
Comment 12
I agree most often you won't have the "time." An even worse danger is that, even if you do have the time, you will think "that isn't my job," or "that's beneath me." Sometimes doing a very simple act of kindness for a pt (even if it's something an aide or a very ordinary person could do) really conveys caring and humility, which can do a lot to win over the pt
Comment 13
"Bargaining" or negotiating with the pt is perfectly legitimate. In the pt/dr relationship, both people have needs, agendas, goals. Making this transparent – perhaps in a playful way – can help the pt recognize her own power, and also remind her that you're both on the same team.
Comment 14
Absolutely! A skilled physician knows how to set limits and be firm as well as how to yield and accommodate. I think the key is to be able to do so from a place of caring and kindness. Then you will be trustworthy in the pt's eyes, even if you're telling her something she doesn't want to hear.

F 16.11.AoD
2.6.11

Comment 1
As well you should have been. This is inappropriate, unprofessional, and probably more. Your intern was asking you to impersonate a physician. It's terrible that the intern was so stressed and overworked, but this was NOT the right way to handle the situation.
Comment 2
Yes, of course you did. That is why it is so unconscionable that he put you in this position. Nevertheless, I think you are right that you should have discussed the situation (not that you or he had time!), refused to deceive the family, but problem-solve other solutions.
Comment 3
So glad you got to speak with Dr. X. Despite the problems the intern faced that night, this willingness to intentionally deceive and lie to family members is extremely troubling. Certainly one option would have been to make a formal incident report; at the least, I think informing his supervisor should have been considered.

F 16.12.AoD
3.13.12
Comment 1
What a great example you've chosen to reflect on – NOT the attending who is the unregenerate racist, but who is a kind, compassionate, dedicated patient advocate WHO ALSO is capable of making dehumanizing and racist remarks. You've complicated the issue, but in a way that I find is more often true to life

Comment 2
It is not appropriate for me to comment on the specific situation, since obviously I don't know enough. But I will say that when people behave in one way as "teachers" or "doctors" and another way when they feel they are in private conversation, those value discrepancies have a way of leaking out. It is hard to be one kind of person in certain situations, and another kind of person when you feel you can "let down your hair."
Comment 3
This is always a real ethical dilemma for medical students, who are the lowest on the medical hierarchy and are very vulnerable to attendings and residents. Each situation requires a moral choice, and it is rarely completely clear what the right answer is. You have to choose your battles; yet each decision of silence means that individual will never be challenged to change
Comment 4
This is definitely a risk, and only you could decide if it were worth taking. Sometimes, when passions are running high, it can be a good idea to let a little time pass, and return to the issue when everyone is in a calmer frame of mind. The trouble is, when we calm down, we decide the easiest thing is to pretend it never happened.
Comment 5
Only because this physician was a mentor, and seemingly had so many positive qualities, I wonder if there might ever be a time (post-clerkship, post graduation) where you could revisit the issue with her and ask her those questions. Never an easy way to confront someone's shortcomings – but if they are never confronted, then there is never even the remote possibility of insight or change.
Comment 6
That you still think about this incident makes me wonder whether by having a conversation with this person at some point might help resolve your regret at not saying anything initially. She might actually benefit from such a discussion; and you might feel you'd done what you could to address an ugly interaction. You know best, and you may have moved on. But it's certainly worth considering how you will handle such situations in the future.

M 16.13.AoD
11.28.12
Comment 1
This patient not only sounds difficult, he sounds almost impossible!
Comment 2
And not much help from the family either.
Comment 3
You know, I'm so impressed that despite the obvious difficulties this patient posed, you were willing to take the time to figure out what exasperated him more than his usual state – and you did find ways of making a horrible situation at least a little less horrible.
Comment 4
Where can you go after you've offered this clear and commonsensical explanation? Perhaps nowhere. Sometimes asking the patient to explain back to you what you've shared; sometimes empathizing ("it's hard when you've never needed a medication before and now someone's telling you that you do"); sometimes asking for help ("help me understand what isn't adding up for you; help me understand better why this sounds so bad to you") – all of these might work; and they might not!
Comment 5
I truly admire this – it can't have been easy.
Comment 6
What a great idea – shift the ground completely! This was brilliant, and it sounds as though, by approaching him as a person first, and patient second, you were able to make some headway.
Comment 7

Great insight – sometimes education itself, no matter how clear and accessible, is simply not enough, if the relational context is missing.

F 17. 10 AoD

1.26.10

Comment 1

And then we shoot you?! Oh my goodness, that is incredibly bizarre. I can easily see your feeling uncomfortable, if not a stronger emotion!

Comment 2

What I find astonishing is the complete lack of self-consciousness about such a crude and hurtful approach.

Comment 3

I wonder what you were feeling – embarrassed, hurt, vulnerable?

Comment 4

And this is interesting too. I'm sure many felt very uncomfortable about this interaction (maybe not that resident!), but they did not know how to support you – and maybe they were afraid to support you! This is how someone becomes stigmatized, turned into the Other, and therefore dangerous to associate with (because somehow you might "contaminate" them so that they in turn would be "picked on" by the powerful attending

Comment 5

Some things are better "let go," but this is inappropriate behavior that rises to a level that ideally requires some response

Comment 6

Excellent distinction. You can be very clear in terms of pointing out someone's unacceptable behavior and setting boundaries without humiliating or embarrassing them.

Comment 7

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.

F 17.11 AoD

2.3.11

Comment 1

Yep, borderlines will do that. It doesn't make it that much easier, but it goes with the territory.

Comment 2

Brilliant, , this is a really important insight. As you probably know, all the "bonding" behaviors you describe above are classic representations of a borderline personality. They vacillate between glorifying and denigrating all their relationships, often depending on whether those relationships are getting them what they want. It is part of a manipulative pattern to elevate a chosen healthcare provider on a pedestal because "she is the only one who understands me." Eventually, however, when this person sets a limit or offers an alternative perspective, the person w/borderline personality will decompensate and quickly "dethrone" their former heroine. Btw, this doesn't mean that you shouldn't try to make an emotional connection with this patient. It just means that you need to realize that that connection is subject to the distortions of the disorder.

Comment 3

Actually, I agree with you and disagree with your attending. Having a borderline personality disorder means that there will be complications and fractures in establishing relationship, but it doesn't mean that the patient should be reduced to a mere object of treatment. Your approach is both more humane and more effective. Working successfully with someone with bpd means winning their trust, establishing that you are a safe person, and within that context, setting those boundaries and limits. It's a balance, where it's easy to err in one direction or the other. But, in my view, both elements are necessary for good patient care.

Comment 4

Hey, thanks for completing this last assignment. I really enjoyed this one, it gave me a chance to put on my old "psychologist" hat. As I'm sure you know, borderline patients are perhaps the most frustrating to work with. In my experience, psychiatrists often loathe them, and dread having them in their practices. There are different legitimate treatment philosophies, but personally I agree with you. You realized that what was happening with this patient wasn't entirely real emotional connection, but part of the patient's disorder manifesting itself. Yet I believe it is wrong to dismiss her positive response to you as "only" her disease. Rather, you did establish a connection, but one inevitably distorted by the patient's axis II disturbance. Once you understand this, you can be alert to the patient's inevitable manipulations (springing from her psychiatric disorder) - "If you were really my friend, you'd xxx..." "If you really believed in me, you'd do this and that" - and be very clear on appropriate limits and boundaries (very necessary with a borderline patient). But it simply is NOT one or the other. The patient deserves your efforts at genuine connection - and she also deserves your help, which will often look very different from ennabling interactions. You didn't get it entirely right in your first encounter, but I believe strongly you were very much on the right track. I made a few additional comments in the text. Best. Dr. Shapiro

F 17.12.AoD
2.15.12

Comment 1

Perhaps your question overreached, but the physician's reaction seems inappropriate and overblown.

Comment 2
I so admire that, despite being mistreated by an experienced professional who should have known better, you chose to reflect on this experience and learn something about yourself. You can't change Dr. N's defensiveness, hypersensitivity, hostility, and punitive response, but you can figure out how you might have pursued your goal of learning in a more skillful way. I agree that by clarifying your objective was to understand better how these mysterious medical decisions were made (as well as clear your counter), you would have reassured Dr. N that you respected her authority, and mitigated her defensiveness.
Comment 3
I'm also really impressed that instead of drawing only general conclusions ("I learned I need to be more tactful"), you generated very specific behavioral and communicative strategies you could have employed. Excellent!
Comment 4
Medicine is a lot less mysterious to the initiated – and your insight shows how much you've grown since you were a naïve pre-med looking for a code. Good medicine always involves listening to the patient as well as assessing the lab results!

M 17.13 AoD

11.30.12

Comment 1

Wow, what an amazing response. You didn't ignore the roll, as I originally thought. You didn't escalate, as would have been understandable (although not productive). Instead, you somehow found the resilience to make a sly joke. Awesome.

Comment 2

Your response also seemed to have a softening effect on your patient.

Comment 3

Humor is often a defense mechanism, true. In this case, you substituted humor for anger (or hurt), but it was not humor at the expense of your patient; rather this humor bonded you with the patient.

Comment 4

Yes, you were impressively successful at seeing what the patient needed and delivering it. The patient was testing you, and you responded in a manner that instantly gained his trust. He saw that you were strong enough to handle a tough situation, yet secure enough that you did not need to attack him back – no war necessary.

Comment 5

this is a great story, and I think the way you handled the roll in the face was awesome. The ability to "read" people and situations is a sign of a well-developed emotional intelligence, and an essential quality for an outstanding clinician. As you note, not every situation calls for humor; it is one arrow in your quiver. The truly skilled physician knows when to pull it out and shoot it. Importantly, humor is most effective when it places doctor and patient on the same side (as you did), rather than push the patient away or bond a group at the expense of an outsider.

M 18.10 AoD

Comment 1

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

F 18.11 AoD

9.2.13

Comment 1

You are a very independent and self-reliant person,. This is so unusual in this day and age.

Comment 2

Ha-ha! It is unbelievable to me that these gender differences persist, but sadly I know they do.

Comment 3

Oh those high horses are so easy to mount! These are lines from a wonderful poem about doctors by Ann Sexton:

The doctors should fear arrogance
more than cardiac arrest.
If they are too proud,
and some are,
then they leave home on horseback
but God returns them on foot.

Nice reminder, huh?

Comment 4

So hard to acknowledge the truth to this, but it is true. We are not the boss of other people, even those we care about (e.g., patients), and even those we love (i.e., brothers).

Comment 5

You've got this absolutely right. You can still hold to your differing views and opinions (which may well have more "right" objectively), but it is how you share this perspective (with kindness, love, caring – and the necessary firmness) that is so important

Comment 6

I'd perhaps say, not "terrible" but probably not as skillful, as loving as you might want.

Comment 7

It sounds to me that, although your brother clearly could learn a lot from you (should he ever be moved to do so), this is a gift he offers you. Not judging a person does not mean you can't have a difference about specific behaviors, values, attitudes. But it means holding these differences in the context of love. Hard to do, but in my experience, when I'm able to pull it off, I not only feel better about myself, but am more effective in getting the other person to at least think about what I'm saying.

Comment 8

I appreciated the real soul-searching in your essay. It is SO HARD to be honest about ourselves, isn't it? Just when we think we are doing so much right, we realize in some respects we are messing up. But such honesty is how we grow and become better people. The pitfall of self-righteousness is an easy one to stumble into, at least in my experience! As I noted in my comments, you may have some wise thoughts to offer your brother about his life. But when these thoughts are offered with judgment and condescension, they rarely find fertile soil. The other person is too busy defending themselves from a perceived "attack" to be able to think seriously about what's being shared. As you say, "correction in love" is what attracts people attention. They can feel that you love them and want the best for them. It doesn't always work, but it has the best shot. I believe learning how to differ with others from a place of love, not anger, is one of the most challenging, but most important lessons we can learn in life. I think it's wonderful that you are mastering this skill at such a young age! Best, Dr. Shapiro

F 18.13.AoD
12.4.12
Comment 1
Oh my. Definitely the epitome of difficulty. I wonder what it feels like to be "banned" from a hospital, the original meaning of which is a "place of hospitality"
Comment 2
Wow, under the circumstances, good for him. How easy it would be to focus exclusively on the medicine and getting the patient out as quickly as possible.
Comment 3
This is a great insight, both in terms of the tension between conscious/unconscious; and regarding the understanding it shows of the painful, unhappy situation that might be driving her behavior.

Comment 4
You understood her, you didn't simply "ban" her; instead you found an option that addressed at least some of her concerns; and in return she was willing to be a bit more cooperative. This is a success story ☺
Comment 5
Excellent conclusion. Understanding the logic and motives behind someone's behavior, although it doesn't necessarily justify the behavior, often provides insights regarding how to better help them. When you can begin to resolve a difficult situation, such as this, your patient will feel better; and as you wisely note, so will you ☺

F 19.10.AoD
9.3.13

Comment 1

Very perceptive. You were the nearest convenient "dog to kick." This in no ways excuses or justifies the surgeon's behavior, but it enables you to see clearly that this isn't about you.

Comment 2
This, I believe everyone would agree, was a very wise choice, especially during an operation ☺
Comment 3
This is known as being rescued by a benevolent other ☺

F 19.11.AoD
2.14.11
Comment 1
The resident displays unprofessional behavior all morning, culminating in threats and intimidation.
Comment 2
It is so sad that this is one of the best-learned lessons in medical school!
Comment 3
For better or worse, human beings are neither mechanical nor predictable. The main tool we have to rein in capriciousness is consciousness – including reflection, awareness of values, and intentions about our own behavior.
Comment 4
I find this such an unfortunate outcome. This is not the lesson medical students should be learning! I wonder if the resident's behavior on this morning was characteristic of how she acted throughout the rotation If so, I wonder if you considered speaking with her, perhaps AFTER you r evaluation had been recorded. Without feedback, there is no possibility that this individual will ever rethink her own behavior.

9.13. AoD

12.2.12

Comment 1

I love these kinds of transformations. And they CAN happen (although we can't count on them).

Comment 2

Haha. Yet this “joke” also set you up a bit to see the patient as your “test,” perhaps even an obstacle to getting a good evaluaton.

Comment 3

Good for you, and under the circumstances very hard to do. Yet it is often the key to good doctoring – when your strategy isn’t working, abandon it and choose another.

Comment 4

This is so wonderful, Joey. THIS is was patient-centered medicine means. When your patient is distracted, thirsty, and needing to urinate, he may not be in the best mood to cooperate with the doctor’s (or medical student’s) agenda!

Comment 5

So by negotiating with the patient, and sharing some of your “interview” power, you were able to satisfy your own agenda as well. Great work!

Comment 6

I’m always impressed at how often (although not always) an apparently cantankerous, uncooperative, annoying patient can be pleasant and participatory once he feels seen, heard, valued, and respected. You did all those things.

Comment 7

It meant a great deal. You were likely the only one whose name he knew, the only one he trusted, and the only one he was willing to talk to. This is a wonderful example of how spending a few minutes listening to your patient and paying attention to his concerns is in fact not “wasted” at all, but the difference between frustration and aggravation and a positive hospital stay.

Comment 8

This sounds awesome, Joey. You and your patient met not only as patient and medical student; but also as human to human, what the philosopher Martin Buber called an I-Thou (as opposed to an I-It) encounter.. This is an essential dimension of a meaningful and successful medical interview. I am very moved that you were able to achieve such a connection with this patient, despite all the initial obstacles.

Comment 9

thanks for sharing this inspiring and beautiful story. Somehow you managed to resist the pressures of your resident to “follow protocol,” and went your own way to establish a patient-centered connection. It really paid off, as obviously you were the member of the team that the patient related to and trusted. This is a classic example of how meeting the patient wherever he is with respect and sincere caring can lead to many good things, not least of which is having a successful interview ☺. I really admire the way you worked with this patient.

2.9.10

Comment 1

It is very frustrating from the dr's point of view when the family cannot accept the reality of the patient's condition. It is also, from the family's perspective, a devastating reality to accept, and often they resist with all their strength.

Comment 2

This is a hard attitude to deal with. No one likes a pt/family member who feels they "deserve" certain things. I wonder if it can be worthwhile to ask, "What makes this pt/family feel entitled?"

Comment 3

Ouch, so not only demanding but racist. Again, as we discussed in the previous class, although this attitude is their problem, sometimes it can be illuminating to ask them why, rather than just acquiescing – or ignoring.

Comment 4

This behavior does sound beyond the pale. You know, I used to tell my kids, "You have a right to ask for whatever you want; but you're not necessarily going to get it." I wonder whether the medical team attempted to establish some boundaries on this family – i.e., negotiate what was and wasn't acceptable.

Comment 5

This is a superb insight,! This is what most of us tend to do in a "reactive" manner – we both enable and complain about it! When you notice this pattern in yourself (as I often have in myself!) or in others, that is a cue to intervene.

Comment 6

You are certainly right that it was not your "responsibility," but on the other hand, it sounds to me you had a lot more insight into what was going on than the rest of the team.

Comment 7

Bingo. You should never feel like a victim, whether of unprofessional attendings and residents, or of demanding patients or family members. Having respect for patients and families by no means allowing them to call the shots, especially in such inappropriate ways. In fact, in my view it would be more respectful to open up a dialogue with this family, ascertain their wants and needs, and then devise a collaborative strategy for achieving these things to the extent reasonable while setting appropriate limits in return.

M 20.11.AoD

10.7.81

Comment 1

I'm glad you adapted so well. This method of teaching has much to recommend it – in moderation – but sometimes you just want THE ANSWER ☺

Comment 2

Unfortunately, this has degenerated from teaching into pimping.

Comment 3

All our experiences, good and bad, can be if we choose building blocks. The question is, what are we building? Is it the right edifice?

Comment 4

I'm so glad that somehow (little thanks to this resident) you were able to extract such wise lessons from such a humiliating experience. That shows true maturity – as well as generosity of spirit. I wonder if you ever thought at some point – perhaps AFTER you'd completed the surgical rotation! – of finding this resident and giving him feedback (in a professional manner of course) about how this incident affected you; and whether there might be other less harmful ways of "teaching." A lot of times we just "shake off" these experiences and move forward; but of course then the person inflicting the damage never even has to think about his or her actions.

Comment 5

Well-said. You've just demonstrated that we can learn a great deal from negative role models – i.e., how NOT to be like them. I think you are absolutely right, there are other, and better, ways of educating learners that adhere to high standards without invoking shame and blame

M 20.13.AoD
11.27.12
Comment 1

How distressing this must have been, especially after an hour of discussion.

Comment 2
You know, that's the thing about human relationships. There are no guarantees that even if you bring self-awareness, curiosity, active listening, flexible problem-solving skills, creativity, patience, and a whole raft of other qualities and abilities that you can control the outcome. After using all the arrows in our quiver, this is where we must learn to forgive ourselves and the patient.
Comment 3

Such a wise insight. You all are used to success – you are used to applying yourself and achieving the desired outcome. You are all incredibly smart, competent people, and this model usually works (more than for a lot of other people). But it won't always work, and that is why we have to make room in our lives for failure – not as something to be feared, but something that (after making all possible effort) can be accepted and learned from

Comment 4

This is one of the things that makes medicine so hard, because when you are not successful, there is often so much at stake.

Comment 5

Great conclusion. This is applicable in many many situations (think geriatrics for example). It's a balance, and it's a balance the patient will determine, although hopefully with valuable counsel and input from her doctors.

Comment 6

Good job, This nuanced list shows me you are in touch with the stew of emotions that can arise as a result of failing to achieve an important goal – and thus, with a better chance of not having them complicate an already very difficult situation.

Comment 7

Yay Dr. X. What can I say, he's the best.

Comment 8

And after you've said (for an hour!), "Help me understand how you've reached this decision," with no further illumination forthcoming, you simply have to let go, not with anger, but with acceptance and, as Dr. B so wisely knows, with a little hope that somehow it will be alright.

M 21.10 AoD

2.17.10

Comment 1

This is a good object lesson in not allowing personal issues, no matter how difficult, to overwhelm your effectiveness at work.

Comment 2

Sadly, I have heard this often about transitional interns.

Comment 3

in NO way do I mean to try to make lemonade out of this lemon you were handed, but it occurs to me that this experience may actually have been good "practice" for internship. As we discussed in one AoD session, burn-out is an occupational risk. You may have been experiencing the early consequences of too much stress and strain.

Comment 4

Good for you. It is sometimes hard for doctors to admit they could use some help, but everybody does; and sharing the burden of stressors is cathartic, and often leads to solutions you did not see on your own. I

can see that next time, when you notice those feelings of chronic anxiety and isolation, you will reach out more quickly, thereby reducing your own suffering and making you a better doctor in the process!

F 21.11.AOD
1.28.11
Comment 1
I'm glad you were able to stand up for yourself!
Comment 2
I'm especially glad your attending was willing to stand up for you as well.
Comment 3
How unpleasant and disrespectful! Do you have any idea what made her adopt such a hostile position toward students?
Comment 4
Sometimes this can be an effective strategy, but sadly not always. This sounds like a longstanding issue that might not effectively be addressed one-on-one (i.e., student to nurse), but would require a more systemic intervention from her supervisor.
Comment 5
Once again, thank goodness you did not have to fight this battle alone. It's obvious that many people, including the attending, residents, and other medical students, agreed this woman was a problem – but no one could figure out what to do about her!
Comment 6
I'm amazed that in a teaching hospital, this person is allowed to get away with such unprofessional behavior. It should not be up to the student to address such a situation; rather it should be handled by the attending, who is responsible for teaching, and by the charge nurse, who is responsible for the professional conduct of her nurses.
Comment 7
That's a good thought. Perhaps she's been able to act in this manner because there's never been a documented record of how inappropriate she is.
Comment 8
There is plenty this nurse could have learned from the encounter, if she'd been willing, but this is what YOU can learn. Usually, at the point that we lose our temper and start shouting, very little positive is going to result. You were right to step out of the OR at this point, but ideally the team should never allow its disagreements to spill over into the patient care arena.
Comment 9
Very well thought through, Now you have a model for next time which is assertive, confronts the problem, but also preserves professionalism.

M 21.12 AoD
3.26.13

Comment 1
I agree wth this observation. In fact, I think in general, such labeling of the patient does more harm than good. Perhaps it is better to speak of difficult interactions.
Comment 2

And this is so often the case in these so-called “difficult” encounters – the patient is confused, poorly informed, and/or her perspective is not being considered.
Comment 3
Here we have an excellent statement of the RESIDENT’S perspective. From this perspective, it makes perfect sense for the patient to wait. But the patient has just had major surgery with a very difficult and distressing outcome – a colostomy bag. What is her perspective? She’s terrified, and wants reassurance from someone she knows and trusts (not some strange ED resident) that she is not in further trouble
Comment 4
Good for you. These are precisely the patients that doctors tend to avoid because they present difficulties and can take up time
Comment 5
Wonderful example of working with your own emotions before encountering the patient. Your goal is not to suppress or eliminate the feelings, but rather to be aware of them, perhaps soften them, and make sure they don’t interfere with patient care
Comment 6
Very good and honest self-awareness of what was going on with you.
Comment 7
Excellent! Empathy might not change your view on how the situation should be handled medically, but it will soften your judgmental feelings and help you understand your patient.
Comment 8
Superb insights. The patient is likely feeling fearful and out of control, both of her body and of the future.
Comment 9
Giving information is always valuable, but giving information that is tailored to addressing the patient’s concerns and fears is ideal. Nicely done,
Comment 10
It is obvious from this statement that you made your patient feel safe enough to disclose her fears.
Comment 11
Outstanding. Her vulnerabilities, insecurities, and fears are driving her behavior in the ED. By eliciting these deep emotions, you are in a much better position to deal with the more superficial issue of whether or not a surgeon should be consulted. When the patient feels seen, heard, and understood, she will be much more likely to follow your advice.
Comment 12
This is what is known as compassion-in-action, Kevin: first, understanding your patient’s concerns; then addressing them compassionately and humbly. No wonder she was appreciative

F 22.10 AoD

1.27.10

Comment 1

Oh my goodness, what a dreadful saga!

Comment 2

Not to justify her difficult behavior in any way, but it is easy for me to imagine indulging in similar behaviors after a 60 day course such as you describe!

Comment 3

Very nice effort at empathy, and an honest admission that, in the same circumstances, you might be tempted toward similar acting-out.

Comment 4

Without doubt, some people are more difficult than others, but it is also true that "difficulty" may well be situational. She might have been a pretty reasonable human being other other circumstances. I admire that, in thinking about this trying patient, you can give her the benefit of the doubt.

F 22.11 AoD

2.13.11

Comment 1

Love the internal dialogue, Sabrina. All the stories we tell about others to try to make sense of their behavior and attitudes – and to rationalize our own!

Comment 2

And your story about this spouse begins to broaden!

Comment 3

You're probably right about this, although it's something we all do. The important thing is that, based on more open-handed (and hearted!) observations, you were willing to alter your initial judgment.

Comment 4

And here your compassion for this little old lady emerges.

Comment 5

What you learned from Mrs. L were crucial "family care" lessons. You did not do anything wrong, but perhaps next time you can bring one or two more degrees patience, tolerance, and kindness to that family member who seems so demanding. In this way you can honor the memories of both Mr. and Mrs. L.

F 22.13.AoD

12.2.12

Comment 1

Wow, this would make an already difficult situation much more challenging.

Comment 2

What an empathic statement,. You are right that, although this was not an objective reality, it was most certainly her experience. Under the circumstances, and especially with her many distorted beliefs, it is understandable that she would try to exercise what little control she perceived she had left

Comment 3

You did the right thing in getting an ethics consult. This is a very complicated situation. I wonder whether psychiatry decided that, despite her delusions and paranoia, she was competent to make her own decisions. I wonder whether she was currently on medications. To me, the essential issue is whether she truly understood – or whether her mental status made such understanding impossible because of her persecutory perceptions. A very hard question to answer satisfactorily, and all you could do is gather the opinions of multiple experts, as you did.

Comment 4

The issue I often struggle with, both when a patients consents to treatment and when a patient refuses treatment, is did they actually understand their choice? If yes, then I agree with everything you say about allowing people to make their own decisions. Often, however, people's "understanding" is colored by so many other factors, including as in this case mental illness, that is is sometimes hard to feel confident that the choice is truly "informed."

Comment 5

this situation troubled me, as I imagine it troubled you. Is a paranoid schizophrenic patient able to make life and death decisions about her own health? I think the answer I'd give is sometimes yes and sometimes no. The original service did the right thing by calling for a psych consult; and you all also made the right move by getting an ethics consult. Did the patient really grasp the implications of her decision to leave AMA? I hope so. But you are absolutely correct that at some point when all avenues have been explored and deliberated on, then you must let go and trust that the patient's best interest have been respected.

F 23.10.AoD

Comment 1

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

M 23.11.AoD AoD
2.15.11
Comment 1
So all systems were go! Talk about great expectations :-(
Comment 2
Honestly, this sounds like a very peculiar goal for any teaching experience, but especially for a sub-I.
Comment 3
And no wonder. I had always understood the sub-I to be similar to an internship (therefore the NAME) in which students were given significantly more clinical responsibility and involvement
Comment 4

I wonder, since there was such a discrepancy, whether you considered trying to reconcile or at least exploring these differing visions.

Comment 5
this is quite understandable. When you are not being treated well (or in consonance with your full abilities), it is demoralizing.
Comment 6
Ah, such a good example of how something [I forget what] trickles downhill. This issue had nothing to do with the patients, yet they ended up receiving less than your best because of problems higher up the food chain.
Comment 7
I respect that you were able to see this – not easy. It is very hard to change others, we have a better chance changing ourselves – and if we're lucky, then SOMETIMES others change in response.
Comment 8
This is so beautifully expressed, Scott. It's surprisingly hard sometimes to pry our focus away from ourselves (as I know), but here you were able to see clearly that, indeed, it is about the patients; and in fact, that was why you'd chosen ob-gyn in the first place.
Comment 9

And I might suggest that, while "covering over" our negative emotions is sometimes an important skill to utilize, being willing to professionally discuss differences and disagreements can also clear the air and lead to more comfort – even if not always agreement – on both sides.

Comment 10

I wish I could hug you right now for this comment (you, on the other hand, are probably just as glad I'm on my computer at a safe distance :-)). This is such a critical insight. As you go on to elaborate, people can be pretty difficult from one perspective; but from another vantage point, we may discover many strengths and positive qualities (as you did). The key is remaining open to the complexity of people – not excusing them in one area because of their excellence in another; but not condemning them globally because of some particular issue. Learning this lesson will make not only patient care and work interactions, but all your relationships more nuanced, fulfilling, and productive.

Comment 11

Again, brilliant. This is the key issue – not your disappointment (justified as it was) or her need for coffee. What is the goal? – how to work most effectively to provide good patient care. Sometimes you will be able to work more effectively with one person than another, but the important thing is to think through clearly how you can achieve the best possible outcome for all involved, given the realities and limitations of the situation.

F 23.13.AoD

11.29.12

Comment 1

In such a devastating circumstance, there are likely no "right" words, in the sense of words that can "fix" things for the patient, although there are plenty of "wrong" words that will just compound the patient's suffering.

Comment 2

Very thoughtful and I hope comforting.

Comment 3

I think you found very good words indeed. You expressed genuine regret, gave her the necessary medical knowledge (but not excessive), and told her clearly, without jargon or obfuscation, the tragic implication.

Comment 4

So, so understandable. One of the great Buddhist teachings that I remind myself of often is "Stay, just stay." The impulse to flee is very natural, but if we can just stay present in difficult situations, we can often be of service.

Comment 5

You may have been surprised because you'd become distracted by some negative self-judgment, but I'm not surprised. Your handling of this painful situation was a model many physicians could learn from.

Comment 6

Again, you showed great care and "compassion-in-action" for this patient both by giving her and her family space, AND in continuing to make yourself available to her.

Comment 7

And this would have been presumptuous – a kind of "false" empathy.

Comment 8

I agree, and thinking of comfort as a “treatment” is an excellent way of investing it with the therapeutic value it most certainly has.

M 24.10.AoD

Comment 1
Hi 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
Comment 2
Yes, this was a good call! I wonder if you thought about talking with the intern privately about her decision?
Comment 3
That could be a good thing, certainly. On the other hand, the intern doesn't learn much about the limitations of her style because people are always "going around" her
Comment 4
And of course the main goal is proper patient care. It is certainly not your job to improve the intern's history-taking or pt interactions.
Comment 5
Excellent alternative if you did not want to have a conversation with the intern directly. There might have been a way you could have talked with her without creating a hostile confrontation; but you might also have judged that she was not open to input from a "mere" medical student
Comment 6
Yes, I think you are identifying a very appropriate and much-needed goal for this intern. Again, not necessarily your job, but thinking about the interests and wellbeing of this person's future patients, something to consider
Comment 7
Yes, I don't think there is one "right way" to proceed. It's a matter of sorting out your priorities and your moral obligations. Clearly, as you describe, by far the most important thing is the welfare of the pt in front of you. You may decide you have some responsibility to point out consistent (as opposed to one-time only) limitations of another trainee. As you say, it's something to weigh.

F 24.11 AoD

1.26.11

Comment 1

This is so sad. If you are on an externship, you are there to learn.

Comment 2

I agree, this is a difficult dilemma. It is a direct conflict of interest between you as the student to be evaluated and the patient. I know many students struggle with this same issue. It's hard to know how to behave in these circumstances. Perhaps as you go forward, the most important thing to remember is that disagreements about pt care always may have negative repercussions for you (a colleague or superior thinks negatively of you) and/or for the patient (misdiagnosis et.), so you must weigh the potential negative fallout to yourself versus that for the patient, and act accordingly. Sometimes the WAY you disagree with someone (respectfully and politely, clarifying their perspective [did this attending really not want to take the time to walk you through the LP or did he really not think the LP was medically indicated?], but stating your own argument clearly and convincingly) can mitigate the negative consequences and still address the patient's best interests. Sometimes you just have to take your lumps – but that is not easy!

Comment 3

I think this does matter, because it speaks to the kind of doctor your want to be.
Comment 4

That's actually ingenious, out-of-the-box thinking

Comment 5

This is the crucial corollary to committing to patient advocacy. Under pressured conditions, most of us will try to cut corners. Some of these corners don't matter, others do – and it's easy to self-deceive ourselves about which are which. Once this happens, we've rationalized incompetent behavior, and are more likely to continue along the same lines. So recognizing that "being busy" is not a reason not to take the best possible care of patients is a really important insight.

F 24.13.AoD
11.29.12
Comment 1
It sounds like your attending was trying to keep you safe, which was an admirable impulse on her part. It is hard to assess physical risk, and of course we all know that patients can become physically assaultive. A lot of this is picking up verbal and nonverbal cues, but of course these are all filtered through the personality and life experience of the perceiver. Discretion is often the wisest course, particularly when you are responsible for another person, as in this case. You might make a similar choice in the future, were you in the role of resident or attending, wanting to safeguard the wellbeing of your student
Comment 2
Here you raise a wonderful question. How much of the threat was "real," and external, and how much of it was perception – and misperception? You bring a very empathic perspective to this patient's plight, and in doing so that empathy often is the antidote to our fear of "the other." Once this patient becomes "dangerous," then the energy of the healthcare team is redirected toward "protection" of self and "innocent" others and away from patient care. By understanding his situation, you discovered other, more therapeutic responses than fear, which allowed you to actually function as his doctor
Comment 3
Indeed, this seems so obvious! I commend you for having the capacity to see this patient as something more than a drug-user, to acknowledged that he had a commonsensical request that everyone else dismissed.
Comment 4

I'm so impressed with you for be willing to consider alternative explanations to the patient's problem, and to be willing to get to the root of the matter. In this case, it led to a very successful outcome.

Comment 5

Brilliant insight, exactly so. If you can figure out the "why," things usually (not always) become a lot easier. Soothing the patient's inner hurt, restoring some measure of control can go a long way toward softening the patient's defense mechanisms.

Comment 6

I very much valued how you were able to see beyond the labels applied to this patient (drug-user, difficult) to recognize that he had a legitimate problem that could actually be solved. It's amazing how returning the prosthesis had such a dramatic effect on his behavior. Sometimes it's the little things, right? You draw a very important and valid conclusion from this experience – getting to the bottom of what is driving a person's "bad behavior" goes a long way toward solving the problem. To do so, you have to keep an open mind and pay attention. You did both. The other thing that impressed me was the inverse relationship you identified between empathy and fear. Sometimes you *should* be afraid of patients, because they intend harm and you are in the vicinity. But you perceptively recognized that by seeing this patient in human terms, you did not fear him. Once fear enters the equation, the caregiver's posture is defensive and self-protective, and little real "caring" will occur. You managed to sidestep that pitfall, and remain connected to your patient. Congratulations on handling this difficult situation so well.

F 25.10 AoD

Comment 1

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! Thank you for sharing this incident. It makes me very happy that you are going to be a physician :-). Best, Dr. Shapiro

M 25.11 AoD

9.2.13

Comment 1

I really am impressed by your empathy for your colleague. You were not “on the hook” here, so could have ignored the chief’s bad behavior. I respect that you noticed and were upset by what was happening.

Comment 2

Ouch. How humiliating for the student and what poor teaching.

Comment 3

I’m very glad to hear this; and as you point out, this isn’t even really about your mistreatment as about your fellow students. However, even one such incident is too much, as it is both unprofessional and also likely to produce cynicism and disillusionment in the learner on the receiving end.

Comment 4

You are probably right. The only thing I wonder about was whether this incident rose to the level of a formal complaint (perhaps not by you, but by your colleague). If there is one episode of bad behavior, it can be ignored, or discussed directly with the offending individual. Patterns of behavior, on the other hand, suggest more deeply ingrained ways of acting that may need more systematic intervention. I honestly can’t judge what was required here. Perhaps this chief was just having a bad month. In these types of situations, I think we always need to consider the personal cost to us of standing up and confronting the issue; versus the need to intervene with someone who otherwise will simply continue repeating the same unacceptable actions. These are judgmental calls, based on situational and personal factors. No right answers!

25.13.AoD
11.26.12

Comment1

Ah, the controlling parent, the nightmare of every physician.

Comment 2
I’m impressed you had the courage to set this boundary. Good for you!
Comment 3
this is an insightful and accurate observation. You had to “treat” both father and son in the sense of trying to manage the dysfunctional dynamic between the two of them.
Comment 4
Wow, this was a simple, practical solution – and, at least in terms of his health care, it actually worked! Sometimes the most obvious fixes are the best fixes.
Comment 5
Indeed they can. In this case, you were able to put a fence around an intrusive, problematic father. I wonder how you might have handled the situation if the father had not acquiesced to this approach. Suppose he had not been willing to relinquish the control he exercised by transporting his son? I wonder

if there would have been ways in the exam room that you could have supported the son's voice (as you did, literally, by asking the father to let his son speak).

M 26.10.AoD

Comment 1
Wow, 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 Steve and get some sleep :-).
Dr. Shapiro

M 26.11.AoD

Comment 1
absolutely not a problem, I'm just trying to tidy up the loose ends of AoD so that they don't follow anyone to graduation :-). Your observations about scut are very interesting, in that what's acceptable is determined by the quality of teaching/relationships on the team. I've heard this from other students as well - i.e., scut is acceptable if everyone is working together to promote good education and patient care; but when it feels exploitative, it triggers resentment. Believe me, insofar as a non-MD can, I do understand your frustration. It is fundamentally an ethical one: when we are treated as means to ends, we (rightly so) feel devalued and dehumanized. I very much liked your ideas for revisiting this situation. It sounds close to what you actually did, but perhaps executed in a more systematic and clear way. It's easy (and sometimes the right thing) to say, "It's only a week," and just try to get through it. But often in making this choice, we are depriving ourselves of either a) a better experience (in response to a constructive dialogue) or b) a sense that we did all we could to improve a situation even if nothing changed. Finally, I so appreciate your empathy for... the villain residents (kidding)!. It is an easy course to demonize others (not that they don't sometimes deserve it), but once we start telling stories about others' shortcomings and limitations, they will rarely disappoint us! Having empathy for others' suffering does NOT mean that you give them a pass on their behavior. From your description, it sounds like these residents were clearly falling down on their job. But bringing empathy to confrontation/dialogue creates (if you're lucky) a context of, hey we're all in this together, I see how overworked and stressed out you are. Can you see my perspective that I'd like to learn one or two things on this rotation? How can I help you to make your life a little tad easier; and how can you help me to become just a bit more knowledgeable? Sadly, speaking

from experience, this approach doesn't always work, and sometimes you definitely need to go over people's heads or adopt a "stronger," more confrontive approach. But you can always escalate, right? Giving others the benefit of activating their higher selves rarely hurts. Thanks for sharing this story. Dr. Shapiro

F 26.13.AoD
11.24.12
Comment 1
How lovely that you don't think of any of your current or former patients in this light.
Comment 2
I wonder if you look back on this now with some empathy and compassion for your former "naïve" self.
Comment 3
I wonder whether the "difficult" interacton was not so much regarding this little patient, but with the panicked and harried nurse, who seemed to miss a good teaching opportunity. I am so sorry that you were left with a feeling of failure.
Comment 4
Oh, it is so unfortunate that you ended up with this feeling. I suspect that there was a lot of helplessness about this baby's dire situation. Unfortunately, the nurse's un-nuanced behavior , looking for someone to hold responsible for something - placed a lot of this – inappropriately – on you.
Comment 5
This is indeed a heavy responsibility. Although it seems in this case that the nurse overreacted to the content of the incident, it is absolutely true that your learning is constructed on the backs and bodies of real living people who are counting on you to treat them with the best knowledge, wisdom, and caring of which you are capable.
Comment 6
Of course it is important to know not to jiggle a ventilator-dependent infant excessively, but I suspect as your attending and residents said, that the risk in this case was slight indeed. The real learning is, as you say, that it is an "incredible, undeserved privilege" to be this intimately involved in influencing the wellbeing of other human beings. I'm very glad to think this is the lesson you ultimately extracted.
Comment 7
Thank you for being so prompt, and for sharing this incident, which I decided was more about a "difficult" (i.e., stressed out, panicked) nurse than a "difficult" patient ☺ Although it was a situation that might have been handled more kindly and productively, I thought you drew a wise and humble conclusion – learning to be a doctor is built on the lives and hopes of real people.

F 27.13.AoD
11.24.12
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Comment 2
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M 28.13.AoD
12.12.12
Comment 1
Unfortunately, the difference in power between doctor and patient sometimes leads to this paternalistic, and rather archaic dynamic. This will not work if we are really striving for a patient-centered approach, as we should be.
Comment 2
You decided to take another look at the situation and use a fresh approach…good call!
Comment 3
Why do you think it took so long? Was this the patient's usual way of interacting, or was something else going on?
Do you think the nature of the procedure might have affected his behavior? I'd be interested to hear your opinion.
Comment 4
Yes, although judging by your ability to search for a better approach, I am hopeful that you will remain adaptable!
Comment 5
Well said, Travis. It is only natural for people to feel distressed when they are forced out of their usual environment to be in the hospital. As you pointed out, it is very stressful. Your understanding of this matter will, I am sure, be appreciated by your patients.

M 29.13.AoD

11.27.12

Comment 1

Sometimes I marvel at just how terrible life has been for some people.

Comment 2

Yes, good insight, and why? Because this “explanation” sounds dismissive and minimizing

Comment 3

I wonder why this course was chosen when all previous work-ups had been negative. Maybe this time an organic cause will emerge and save everyone.

Comment 4

Yes, but what kind of help? These hospitalizations are certainly a cry for help, but is she going to the right source?

Comment 5

This is one of the hardest feelings in medicine, as your whole reason for being is to render help and provide answers. But as you wisely note, this is an aspect of medicine that all doctors have to come to terms with. It is the mystery of medicine.

Comment 6

This might have shed more light on the patient’s suffering.

Comment 7

Great insight,. In part, of course, it’s because she’s taking up a valuable bed; but it’s always because she makes everyone on the team feel like a failure.

Comment 8

Yes, shifting the ground does require courage, but if you do it compassionately and without judgment, the patient just may follow along. In these situations, emphasizing the mind-body connection (come to the AoD lecture Dec 6!) can be very helpful.

Comment 9

I suspect you got the diagnosis right. This is probably a problem rooted at least in part in the patient’s troubled past (especially the rape). It is not that it is “all in her head,” but that the traumas of the past are wreaking havoc on her body, albeit mediated by her brain. Psychiatry could be helpful, as you suggest. So could a good primary care physician. Much psychosomatic illness can be managed successfully in an outpatient setting by a physician who is “unafraid” and skillful in guiding the patient to an understanding of their suffering.

M 30.13.AoD

11.26.12

Comment 1

I agree, not an auspicious beginning. But in desperate circumstances, people can do desperate (albeit wrong) things.

Comment 2

And from bad to worse. What a terrible oversight, which may have involved lack of clarity on the part of the medical team; and lack of desire to hear this aspect on the part of the family. All the more reason to ensure everyone is on the same page.

Comment 3

I wonder what their aggression was focused on; what were they "demanding"? Without understanding all the circumstances, this sounds a bit like unresolved anticipatory grief.

Comment 4

That is indeed tragic. Perhaps (but of course only perhaps) had it come out earlier, it would have been something that the team and the family could build on.

Comment 5

Both good self-awareness and good understanding of the family perspective.

Comment 6

Yes, ideally multiple team involvement can lead to first identifying and then reconciling different perspectives in ways that serve the best interest of the patient.

Comment 7

Yes, you're right here, sadly there are no magic bullets. I believe that, although the family was clearly behaving badly, an approach that recognized their grief AND GUILT might have moved things in a better direction. But perhaps not.

Comment 8

It sounds like all sorts of familial, cultural dimensions were in play. Not to mention desperation, which can cause people to behave in less than ideal ways. The "brokenness" of the relationship between family and medical team occurred at the very start of the encounter, and was never really repaired. This limited the ability of the team to render truly optimal care in a context of mutual trust and respect.

F 31.13.AoD

11.25.12

Comment 1

Yes, often a sign of difficulty.

Comment 2

What most doctors long for, but for better or worse, unfortunately not how medical encounters always end up.

Comment 3

Really nice insight,. To work even moderately successfully with this patient, you'll have to change your goal of diagnosis as the only valuable outcome

Comment 4

Wonderful questions! You recognize your cynicism (likely well-founded), but challenge yourself to keep an open mind to other possible explanations.

Comment 5

Exactly. You do not have to agree with the patient's analysis or experience, but you can accept that it is their experience.

Comment 6

Another insightful observation. This patient demanded a lot of you, and it wasn't always stuff that you necessarily wanted to give. And again, perhaps correctly so. You have a right to evaluate the urgency of the patient's demands, just as she has a right to make them. If there is the time to develop an understanding of her "neediness," so much the better. With all these requests for ice water and meds and tvs, what is she really asking for? Validation? Attention? Respect? Is there an axis II diagnosis in the mix? Thinking about what is driving the patient's behavior can often provide a clue to how to respond.

Comment 7

Yes, and again perhaps rightly so. But while this sort of griping validates our perspective, we miss the opportunity to learn something from the experience.

Comment 8

I really commend you for this conclusion, Shawna. By being curious about your patient, you can perhaps learn something for the next time.

Comment 9

This is a very touching and humble way to end this essay!

Comment 10

It is chock full of wonderful insights, including (as a future internist) your love affair with the differential diagnosis (not that I'm putting that down, but it's easy to punish the patient who doesn't yield a recognizable diagnostic endpoint); the easiness of grumbling about an aggravating patient with sympathetic others; the draining aspect to such patients which makes their care so frustrating; the reflexive skepticism triggered by certain patient presentations. These all show impressive self-awareness. Thank you for sharing this encounter, and I'm thrilled that you have extracted so many rich lessons from it.

F 32.13 AoD

12.2.12

Comment 1

This failure to address an obviously relevant issue at an earlier point in care makes such a family conference very difficult, as this concept needs to be introduced de novo.

Comment 2

you did a great job of "double-movement": understanding and empathizing with the family's perspective; while using your medical knowledge to realize that the chances of the patient being restored to a meaningful level of functioning was low. Although understandably family members may initially resist this medical perspective, it is one of the most important things you have to offer them; and really one of the main reasons they are talking with you in the first place.

Comment 3

Here is a crucial insight. When the team and the family are able to find common ground (ensuring the comfort and dignity of the patient), when the family feels the team UNDERSTANDS their hopes and needs, then things can move forward.

Comment 4

Thank you for this description of a family conference that initially began with the family and medical team with contradictory perspectives, but resolved successfully around the common ground of ensuring comfort care for the patient. When the family feels heard, seen, understood, and respected – when their needs are honored (not necessarily met, but recognized) – often things can move forward much more smoothly. I admired your ability to see both the family's hopes as well as the medical point of view. A good doctor has the skill to move back and forth between both.

F 33.12 AoD
9.2.13
Comment 1

you are such a good writer. This is a powerful opening line

Comment 2

Haha. And a little mordant humor never hurts. For better or worse, I think we forget less than we'd like to believe. All it takes is a little Judy Densch to bring it all back!

Comment 3

What a great set-up. The reader is expecting this to go one way – and then you (or fate) jerks it in another.

Comment 4

Your description makes this patient's death vivid and palpable. Your keen awareness confronts the limits of what one human being can do for another – you were with him and supported him, yet he had to face his death alone.

Comment 5

You must have been frightened, at least upset. It's not like in the movies.

Comment 6

I'm glad you were able to see both the distress in response to the patient's dying process, and the calmness required to write the comfort care orders. Both are needed in moments of extremis.

Comment 7

To me, this response is a missed opportunity. It misses the chance to process the student's (understandable and normal) pain; and it misses the chance to grieve for, or at least acknowledge, the passing of a human being. It is true that the patient's death might mean less work for the team, but this is probably not what needs to be prioritized. I actually think this happens (and it is not an uncommon response) because everyone is feeling badly and they want to feel better – so the thought is, less work, I should feel good! But of course this is not the best way to resolve feelings of distress and suffering.

Comment 8

As we discussed in a recent class, what we need is a culture shift in medicine, so doctors would not have to surreptitiously wipe their eyes and pretend they felt nothing at the passing of a patient; and colleagues and team members would feel they had permission to speak to and console each other's sadness, helplessness, and even grief. It is hard to do this when it is not culturally normative; but on the other hand, when enough people challenge behavioral norms, cultures begin to change. Be the change you want to see, yes?

M 34.14 AoD

11.28.12

Comment 1

This was a terrible dilemma. I've always thought that working across language and culture to treat mental illness is an almost insurmountable challenge. It is complicated by the fact that, as cultural psychiatry research teaches us, mental illness itself is strongly influenced by cultural factors, so it is very easy to lose one's familiar anchors.

Comment 2

I respect and appreciate you so much simply for asking this question. Through it, you show that you were concerned not only with making an efficient disposition, but with whether you even understood what was really happening for this patient.

Comment 3

A good observation. Interpreted interviews are better than nothing; and with a skilled interpreter can become an impressive approximation of actual direct communication, but the introduction of a third party presents all sorts of potential complications to the doctor-patient relationship.

Comment 4

You've got this exactly right. More than actual medical error (although that is also a real risk in cross-language encounters), it is trust that is at risk in such interactions

Comment 5

Very nice empathy for language-limited docs. You see clearly now how lack of language proficiency can contribute to the uncertainty and pressure of clinical practice. It is easy – although wrong – to turn that distress on the patient ("why can't these people learn English?"). A better response is to learn Spanish – or hire a really good interpreter!

F 35.13.AoD
11.26.12
Comment 1
Yes, I would find this frustrating as well, because these are the tools we rely on for change, especially in psychiatry.
Comment 2
Excellent insight,. This is very well observed, and tells us a lot about this patient.
Comment 3

These seem logical questions to you and me, but what is interesting (important) is to understand how he sees his situation as NOT a problem.

Comment 4
It is interesting how often transference and countertransference play a role in patient-doctor relationships. How good that you were able to see this connection!
Comment 5

Aha – and now, as the "doctor," you were supposed to "fix" everything again!

Comment 6

Nice work, you are definitely getting at the root of your "frustration" with your patient. When we are willing to deepen our understanding beyond clichés, we actually learn something!

Comment 7

And this is something that perhaps needs to be forgiven, so you can avoid having it interfere with current situations

Comment 8

How great that you were able to approach both your patient and your past self differently – with greater compassion and greater wisdom.

Comment 9

I am so impressed by your capacity to dig deep, going beyond the cliché of "frustration" to excavate a 9 year old unresolved guilt activated by a current-day patient. As you saw, the one contributed to and complicated the other. When we separate and sort out our various issues, it is easier to understand them – and often easier to bring them to resolution. Nine years later, you realized you were a good and faithful friend to this abandoned boy. You also realized it is not your job to "save" your patient as much as it is to treat him with care and respect. Such good work!