1.12.21

Comment 1

It sounds like your residents prepared you for the possibility of the crash Cs, but did they offer guidance about how you could prepare yourself by scrubbing in early? If they were the ones who provided you with this instruction, then they should also have paved the way with the scrub tech so that everyone was on the same page.

Comment 2

I don't know too much about the OR situation, but from you you describe this was a very patient-centered decision and I respect that you prioritized the patient's comfort over your own learning.

Comment 3

It's great that you approached the scrub tech afterwards, and apologized for inadvertently adding to the already considerable stress of the situation. It seemed to me from his response that since his responsibility was primarily ensuring a sterile field, in this high pressure situation he didn't know if he could trust you to gown and glove properly. This suggests to me the disagreement could not be resolved between the two of you, but that the scrub tech needed the support of a higher authority to affirm that you were indeed expected to gown in by yourself

Comment 4

I think you approached your residents for validation and support, but you did not really receive a clear message from then. Instead, they seemed to equivocate and just said the crash C-section is very stressful, perhaps implying that it is up to the scrub tech to decide what additional stressors they can handle. It still doesn't sound as though the situation was resolved. Perhaps, because you did miss a significant educational opportunity, it is something that needs to be resolved at the clerkship director level.

Comment 5

I agree. You took time to assess what happened before taking action. Then you were appropriately assertive - but also generously apologetic since you really hadn't done anything wrong - with the scrub tech. You processed the experience with the residents, who were sympathetic but ambiguous

Comment 6

Feeling frustration and intense emotions is just part of being human. But the question is, how can those emotions help you reach your goals? Yelling at people (a possible result) usually leads nowhere. By contrast, when you collected yourself and allowed the "mud" of your initial reaction to settle, you had greater clarity and could proceed in a professional manner.

Comment 7

this must have been a very frustrating situation, especially when you tried hard to ensure that you would not be in the way or add to the stress of the situation. I might be wrong, but it sounds like it might be a systemic more than a personal issue: are there guidelines in place for the inclusion of med students during crash C-sections? If so, then they need to be reviewed, clarified if needed, and enforced.

Your essay also raises that perennial issue of the tension between the student's learning and the patient's wellbeing. As you rightly concluded, the patient always is the priority. That said, at an

educational institution, the responsibility of all involved is to do everything in their power so that these two objectives are not at odds. That means well-thought-through and constantly evolving policies and procedures that are seamlessly integrated into the daily practice of the medical center and clinics.

Finally, you recognized your own emotions of frustration and distress and how these might complicate an already fraught circumstance. Instead of allowing them to drive you (yelling at the scrub tech, for instance), you allowed them to settle before appropriately acting on your concerns (talking with the scrub tech and the residents). While the outcome was not all you hoped for, you brought this issue to their attention in a professional, collegial way. In my view, this was the best way forward and hopefully it will lead all those involved, as well as the OB-Gyn department to consider how best to include medical students in these stressful but high-learning situations.

10.12.21

Comment 1

This does sound very frustrating, Andreea. The team tried hard to keep the family updated, but was not able to meet their expectations. I wonder whether it was ever possible to address this discordance - i.e., to have an honest conversation with the family about what could help them feel more included in understanding the care their loved one was receiving. This kind of communication is especially difficult across language and culture. There are no simple answers, but perhaps the most important thing is to simply stay the course, and not allow discouragement, however understandable, to dominate the interaction.

Comment 2

You and the entire team were trying really hard, both in terms of spending extra time with the patient and making an extra effort to keep her oriented and aware of her own care and the family apprised of her evolving status. Under these circumstances, it is really easy to become attached to certain outcomes, to expect that the patient (and by extension their family) will transform into trusting and grateful people. Often, in fact, this is precisely what happens. But it's important for us to remember that we act in these ways to enable a better experience for the patient, but also simply because it is the right thing to do for patients and families who are scared and vulnerable.

Comment 3

Awesome. I am so impressed that you and the team never gave up, you simply kept trying one approach after another. These massive multiple teams/massive family meetings are a real nightmare to organize, and I commend you all for going this route. The system of appointing a family "spokesperson" with whom all communication occurs is efficient from the hospital point of view, but it is simply not how all families work. Family dynamics have strong cultural roots and sometimes violating these will lead to communication failures and breaks in trust. In this case you prioritized a patient/family-centered approach; and you finally won them over. You earned their trust.

Comment 4

This is another great example of how different perceptions can lead to different conclusions; and often create tension and conflict. If the approach is my way or the highway, there are likely to be a lot

of hard feelings from the "losing" side; yet these are also people on whom the "winning" side will be relying. This is a situation you want to avoid if possible.

Comment 5

And you did. Beautiful teamwork! You listened to each other's concerns and ultimately brainstormed a ingenious (and I might add, very family-oriented, family-inclusive) solution (which no doubt pleased the family),

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10.12.21

Comment 1

It is so common that emotions circulate and escalate in exam rooms - both positive and negative ones. An important but hard to master skill, as I'm sure you know, is to learn to keep your emotions steady (not turned off) even when patient/family are anxious, angry, etc.

Comment 2

Of course, when patients are anxious and tense, it is hard for them to trust anyone, especially when the people they must trust are strangers, and the stakes are high.

Comment 3

It's great that you decided to stay with the patient, even under less than optimal circumstances. I wonder whether the patient asked you this question. Even if she wasn't able to articulate this, I wonder if you thought about addressing her fears or assumptions, no matter how misplaced. It's easy to glide over unstated questions, especially if they are uncomfortable for everyone, but sometimes it helps to bring them to the surface.

Comment 4

Debriefs are such valuable learning experiences yes, for students, but for everyone concerned. Through even a few minutes of reflection and sharing, we see ways that we can do a little better next time around. This is something that should make us all not ashamed but happy.

Comment 5

I'm so glad to see that your attending handled this sad situation with empathy and clarity. Great modeling for you. Also, outstanding that there was a debrief from which you could all learn something. These opportunities to think about difficult situations not with shame and blame but with curiosity and commitment to self-improvement are really valuable and it's great to see them becoming a more regular part of medical care.

One other thing I wanted to add has to do with not mirroring the negative emotional environment in an exam room. Our mirror neurons can create empathy but they also predispose us to reflecting the problematic emotions of anger, frustration, mistrust, defensiveness etc. that can fill the room. It helps when you can maintain a certain emotional steadiness combined with compassion even in the face of problematic patient/family emotions and behavior. This actually gives you a better chance of calming the situation and creating an optimal outcome.

10.11.21

Comment 1
Yes and tragically this shows that when we do not have good systems supporting us, the result too often, despite, individual efforts, is moral outrage and distress.

Comment 2
This just sounds agonizing - for the team. I cannot imagine what it must have been like for Mr. Johnson. It is truly appalling - and sadly just one more awful story to add to VA medicine.

Comment 3
This is so horrifying. Yet we have to wonder about her level of burnout, fear, resentment and cynicism that has resulted in such terrible unprofessional behavior.

Comment 4
It is very moving how the intern, the team, the medical student gave 110% trying to get appropriate care for Mr. Johnson. But it should NOT be this difficult. It should not be the individual physician's responsibility to beg and plead with nurses, techs, neurosurgeons to get help for their patient.

Comment 5
Just one systemic disaster after another. NO wonder you all felt so awful. Each time you went above and beyond, you hit a brick wall.

Comment 6
You know, if there is any bright lining - and it is a small one - it is that Mr. Johnson knew you all were on his side and fighting for him. It doesn't make up for the disgraceful way he was treated (or more often not treated), but I think it helped him to feel he was a human being and not just a problem.

Comment 7
To be honest, most of this was out of your hands and that is all you could do.. You kept pushing for your patient. I'm not surprised you were crying at the end of these horrific 36 hours, and only glad that you were able to vent a little with each other and with your support people.

Comment 8
This is so healthy. Increasingly, teams are holding these debriefs and I hope the day is not far off when they are a standard part of every difficult encounter.

Comment 9
I found this very inspiring. In such a situation, it is tempting to just wash your hands of the whole awful mess and focus your energies on a more hopeful situation.

Comment 10
What a wonderful conclusion, Gladys. This realization lies at the heart of healthy physicians and healthy patients.

Comment 11
this is a truly extraordinary essay. Unfortunately it is also ordinary, because what you document happens all too frequently. It was especially heartbreaking that, experiencing inequity and injustice, Mr. Johnson was uncomplaining and dignified.

It is easy to blame the hardhearted and indifferent nurse, tech and anonymous transfer center (which nevertheless is made up of human beings). Yet they too are likely burned out, overwhelmed,

underappreciated and self-protective. That in no way justifies their behavior; but it reminds us that if we put ordinary people in terrible situations, they will often choose the path that benefits them most or harms them least.

What does come through very clearly is your great compassion for Johnson and the truly heroic steps you tried to take on his behalf. At every point you all advocated for him and fought for him. It wasn't phenomenally successful, but had you NOT done this, the outcome likely would have been even worse. Mr. Johnson understood that, and I think that made a difference for him. At least in a very unfair system, he was not alone.

I was also so glad that you debriefed with you team (and with your support system). When we see institutional injustice, it's hard to accept and it's easy to question what we see. "Maybe I'm missing something, maybe there's a reason why these people are behaving so heartlessly." When other people confirm your perceptions, it can give strength to cry tears of frustration then get ready to fight another day.

your future patients will benefit from your kindness, your commitment, and your advocacy. We need new healthcare systems and I hope you will do your part to create them. Until that happens, at least you can witness your patient's suffering and reassure them that you see their truths.

10.11.21

Comment 1

I'm sure the family was very "demanding". However, when negative labels like this get attached to patients/families, they encourage us to form stereotypes and make assumptions about patients/families rather than assessing for ourselves where the problems like.

Comment 2

These circumstances do not justify "demanding" behavior, but they make it understandable to some extent, yes?

Comment 3

This is only one example of the unfair burdens often imposed on Spanish-speaking medical students.

Comment 4

I very much admire that your curiosity and concern for this patient led you to discover a much more nuanced picture than the one presented in the chart.

Comment 5

I agree - this was indeed brave of you, and shows me you were putting your patient before potential ramification to yourself.

Comment 6

you make so many important points in this essay. One has to do with how linguistic and cultural misunderstandings can quickly morph into discriminatory and inequitable labels that do harm to patients. Another is that these same differences can also result in inadequate diagnostic work-ups and evaluations. A third has to do with the courage it takes for the student "on the bottom" of the

hierarchy to speak up and question the received wisdom - and how important this can be. A final one has to do with appreciating the difference between medical hope (which emphasizes what is and what is likely to be) and familial hope (which emphasizes commitment to the loved one and what might just possibly be). It is not that one is right and one is wrong; but rather that too often medical professionals treat family hope with disrespect and even scorn ("family is in denial," "family has unrealistic expectations," "family will not accept reality"). Please understand I'm not saying the family's hopes should prevail, but just that they need to be treated tenderly and empathically and approached in a way such that changing them does not feel like a betrayal of their beloved grandma or father, uncle or child.

I'm glad to see you are willing to take on the added but necessary role of advocating for non-English speaking patients. They should not be penalized for not speaking fluent English; and their families should not be shamed for holding different views about their wholeness and chances of survival.

10.11.21

Comment 1
You are also well aware - and rightly so - that it takes two to do a difficult tango; and that the med student or physician brings their own stresses, anxieties, and exhaustion to the encounter.
Comment 2
Awesome. So hard to do - but if you can take that step back and think about the big picture, EVEN when you are stressed, annoyed, and tired, often really valuable insights emerge (as in this case).
Comment 3
Excellent effort to put yourself in the patient's shoes - no doubt he is feeling very confused and frightened, and trying to regain control by being uncooperative and threatening to leave AMA.
Comment 4
What's most important here is your ability to own when you are less than perfect, and your willingness to try again. This is what makes a good doctor.
Comment 5
So nice - rearranging your schedule, clearing as much as possible, doing a "reset," sitting down, and being cognizant not to add your frustration to his.
Comment 6
Exactly. There is nothing magical here - your patient may still feel resentful, lost, and scared, but you are letting him know that you're on his side, and that almost always helps. It builds trust, and that is when patients start to talk honestly with you.
Comment 7
Yes, yes, yes. It's easy to take refuge in the small details, but once in a while it's important to remember to see the whole patient in the context of their lived life.
Comment 8
Absolutely. Apologizing, asking forgiveness, and trying again are some of your most useful tools in dealing with difficult encounters.
Comment 9

So no magic. But think about how much more demanding this patient might have been - or how much worse care he would have gotten AMA then likely rushing to the ED - without your patience and concern.

Comment 10

you handled this patient with professionalism and compassion. You were aware of his stressors and anxieties and you were aware of your own. It didn't go perfectly smoothly the first time around but importantly you recognized that and committed to trying again. By listening carefully, understanding his perspective, and providing frequent updates you built trust and provided patient-centered medicine. This was not an easy encounter, but it would have been so much worse if you had escalated out of defensiveness or resentment. You likely would have lost this patient and his healthcare would have suffered significantly. Your kindness and concern kept him in the system and got him the care he needed and, importantly, that he was willing to accept. A problematic beginning still has the potential for a positive ending.

10.12.21

Comment 1

This is the disappointing thing - I understand how hard it is to push back, even gently, against one's superior, but when we say nothing (something I have definitely been guilty of) the offending person learns nothing.

Comment 2

Ouch, ouch, ouch. So inappropriate, so unprofessional. I can't believe people still feel free to make remarks like this, although in fact it seems as a society we are more and more unfiltered.

Comment 3

This is completely understandable. When this level of cognitive dissonance occurs, we often question ourselves: Did I mishear? Could he have meant something different?

Comment 4

This is an excellent point as well. Although it is understandable to want to vent our own rage, such an approach is rarely effective in promoting a dialogue. Better to calm down, compose yourself, and then pursue.

Comment 5

You know, this cuts both ways. Everyone in that room heard the resident's statement. No one said anything. So in a way everyone was complicit in "endorsing" it. By bringing it up in the same setting, everyone might have had the chance to examine their own behavior. On the other hand, if the resident just ends up feeling humiliated and defensive because of the public setting, he will be even less likely to learn anything. So to my mind it's a very hard call.

Comment 6

And this is a sad reality of medical training. I have heard this concern voiced countless times by medical students and it makes complete sense. Your interests should not be put in opposition to the patient's interests, yet so often they are. It becomes a question of weighing the risk to you vs. the benefit to the patient (and the resident's learning) and how to resolve these questions is by no means clear-cut. You simply have to take it situation by situation.

Comment 7

I very much appreciate your honesty and thoughtfulness i this essay. Most of us are not quite as perfect in real life as we are in our mental dress rehearsals! I personally have done exactly the same thing - stayed silent from fear of the consequences when I knew I should speak out. All I can say is that by not rationalizing our silence, and instead honestly but not harshly examining it, we can learn to overcome those initial reflexive deterrents.

This is exactly what you did, and I sincerely commend you for the way you continued to mull over how to confront similar situations in the future. Speaking from outrage momentarily feels good, but is not often effective. Finding your center and speaking compassionately yet directly tends to disarm the other so that they might actually listen to your perspective. It was impressive that you took the time to discuss the situation with your support system, and to develop different scenarios of responses. This tells me you had not only a visceral moment of discomfort but also a deep commitment to addressing such unprofessional, judgmental, and racist remarks in the future.

Finally, as you note, time and place are important. Just remember, "later" is not the same as "never." Once the heat of the moment has passed, it's easy to move on. We need to remember to circle back to the things that matter, to the things that won't change unless we help them to change.

, don't punish yourself for this one incident but, as you've so ably demonstrated, prepare yourself for all the similar future incidents that (sadly) await you. You are truly the advocate and defender of patients who, as in this case, may not even be aware of the prejudices and biases of their physicians. As you clearly are, keep looking for ways to not let these doctors continue to perpetuate their discriminatory beliefs and practice without a challenge.

10.11.21

Comment 1

Very generous and patient-centered of you, and also another burden routinely - and unfairly - placed on dual language med students.

Comment 2

You are asking exactly the right question and your confusion shows why medical students should not be used as interpreters, as such conflicts as you experience arise regularly. Even as the medical student and therefore the low person on the totem pole, confronting resident (and by implication the silent attending) would have been very challenging. I hope there would be a way you could find to do this without without jeopardizing your standing on the rotation but point out to the resident the inappropriateness of such remarks. It is always a risk/benefit situation, and another example of somewhere a medical student shouldn't have to be. In other words, it should not be your job to educate your superiors - but on the other hand, sometimes there is no one else around to do it!

Comment 3

It is natural to question your observations when you are the list experienced person in the room - but please member that as a human being, you are NOT the least experienced person there and indeed may be open to emotional undercurrents that experienced clinicians have become desensitized to.

Comment 4

And I hope you learned that, while sometimes you will be shot down, sometimes, just SOMETIMES, your superiors will be grateful for the insights and ideas you've contributed to the care of your patient!

Comment 5

you were in a very difficult situation because of your willingness to act as an interpreter (which I've noticed most dual-language medical students do). It comes from a beneficent impulse, and often does benefit the patient, but as you discovered, it can lead to a conflict of interest between interpreter role and med student role. (To be honest, I'd pray that even an interpreter would try to help the resident speak with more respect and kindness, although that would be asking an awful lot of an interpreter). You also had to confront the dilemma of being the low-status person in the room, yet having a moral responsibility to advocate for your patient.

The turning point, as you learned, was sharing your distress with your fellow student, and learning that in fact they shared your discomfort and perspective. When we suffer alone, we think we are the only ones. When we begin sharing our concerns, it turns out others may validate our point of view. This experience gave you the courage to commit to patient advocacy, and you started with very concrete and helpful patient-centered steps. I am certain the more you practice this role, the more comfortable you will feel in it, and the more positive feedback you will get from your patients (and hopefully your superiors).

The final piece is how or if to call out the resident on their inappropriate unprofessional behavior. This can be very difficult to do as a medical student. At the same time, if nothing is ever said by anybody, the resident will likely not change and may indeed not have a clue that there is anything lacking in his behavior. It is not always necessary to confront someone directly, especially when you have significantly less power. For example, you and your classmate might approach the clerkship director at the end of the rotation, after evals are submitted, and note the difficulty. One of the problems is that in medicine, we are not used to sharing constructive feedback, so discussing such incidents always feels punitive. If such exchanges were seen not as punishment but as learning, we would all be a lot better off

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10.11.21

Comment 1

Very important insight. Things have just change in an instant for this family in ways that are both dramatic and devastating. They have not yet absorbed the full implications of what has happened to their son. To expect them to do so is insensitive and actually cruel.

Comment 2

And the attending is probably thinking of their next patient and next family and all that needs to be done beyond this room; and they want to resolve this situation humanely, of course, but also quickly and completely, so it doesn't become protracted and they don't have to revisit it.

Comment 3

Good empathy for the attending as well - the attending is not God, just an imperfect human burdened with the impossible responsibility of telling a family that their previously apparently happy, well-adjusted son is essentially brain-dead from an act of suicide. There is no good way to do this.

That said, as the observer (always an easier role!) you can see some of the common errors - speaking too quickly, not giving the family time to absorb the news, sounding more abrupt than caring (although in fact the attending might have felt just the opposite, but to hold it together they might have relied on a certain harshness rather than open-heartedness).

Comment 4

Beautiful! To me, this is exactly how it's done, i.e., to use your "less than compassionate" feelings as cues to question whether there might be a more humane way to proceed. Taking into consideration the father's desire to be there for his son does not mean doing what he wants, especially when it is futile treatment. But it does mean acknowledging and respecting his commitment to this child.

Comment 5

I'm sure you've heard it said that the physician who stops finding it difficult to deliver bad news should find a different profession. It should never become easy, but I think good physicians become comfortable with the discomfort and pain of this act

Comment 6

Very impressive - this is clearly an attending who takes the time to get it right and who, as you noted above, cares about his patient and the family.

Comment 7

And btw, in my view the physician showing this kind of emotion in the face of such devastating events is simply demonstrating caring for the patient and family. Nothing to be embarrassed about, rather something to cherish. It is the human response and, in 40 years of observing doctors and patients, I have never once seen a patient or family member upset by a physician's appropriate display of sorrow and grief.

Comment 8

And btw, in my view the physician showing this kind of emotion in the face of such devastating events is simply demonstrating caring for the patient and family. Nothing to be embarrassed about, rather something to cherish. It is the human response and, in 40 years of observing doctors and patients, I have never once seen a patient or family member upset by a physician's appropriate display of sorrow and grief

Comment 9

, I suspect this is a family you will always "carry in your white coat pocket," as it is sometimes expressed. It is possible to feel great sorrow AND to experience great learning and growth, and it seems to me that is what you did. I very much appreciated how you had such a nuanced appreciation for the father, the sister, and the attending. You understood with great clarify the likely emotions of each and how these emotions might help or hinder the best outcome for the patient.

Emotions carry the human side of medicine, so the goal is not to ignore them or thrust them to one side, but to examine them for what they can tell us about how best to care for the patient and family. In this case, respecting the father's loyalty to his son was a way of telling him that he was a good father and that by not seeking further medical intervention, he was not abandoning his child. The physician's own discomfort and anxieties could have led to his running away from the whole

situation as quickly as possible; instead he persisted in strategizing what combination of compassion and clarity was most needed by the family. Finally, being patient with the sister's grief led to the painful realization that her brother would not want to live in this state. By monitoring the emotional currents of these meetings (including your own, the initial judgment, the compassion, the discomfort, the tears), you learned a great deal about humane yet direct ways of navigating these terrible situations. Well done!

10.14.21

Comment 1
This sounds so awful. I'm trying to imagine learning I have cancer while sitting in a wheelchair waiting for an elevator.
Comment 2
This is very perceptive on your part, and makes sense to me. It is worth keeping in mind for future patients that, for a variety of reasons (information overload, fear of suffering and death, worry about financial impact), such a diagnosis becomes "just too large to bear." It is critical that the physician delivering such devastating news recognize its weight and find a way to make it bearable (i.e., heard and understood) for the patient.
Comment 3
If this dialogue is an accurate representation of the attending's behavior, it is a good example of how the need to convey content information resulted in overlooking (and therefore not addressing) the human impact of this encounter.
Comment 4
Thank goodness you were able to fill this gap between biomedicine and humanism. It should not have been the responsibility of the 3rd year medical student to account for the patient's humanity, but if not you, then it seems like the person of the patient would have been ignored entirely.
Comment 5
And again, this may not have been the precise language of the attending, but note how the passive voice (such a favorite in medical documentation) absolves the healthcare profession and individual healthcare practitioners (including himself) of any responsibility for this misfortune. It is a kind of rote dismissal of a very fixable problem, implying that "these things happen," like rain falls or wind blows.

Comment 6
As a new 3rd year, it is very hard to judge these situations and take a stand. You are still trying to learn how things work, what is normal, what is acceptable. It is a sad fact that too often we deny or rationalize a rather obvious reality by thinking, oh what I'm feeling and thinking here can't possibly be right, these more experienced folks must know what they're doing. Not always!
Comment 7
I agree completely. Debriefs are invaluable tools - even if very "brief" :-) - to help us unpack and learn from difficult experiences. We have the understandable tendency to avoid debriefs with the excuse that we are "too busy," and prefer to skate past situations where we have to acknowledge our behavior could be improved. But if we can get past these feelings of shame and embarrassment, we

realize that no one is perfect, everyone can handle such a difficult circumstance in a less than ideal way. Recognizing the shortcoming is the first important step toward doing it differently the next time.

Comment 8

this is such an illuminating example, and I can see why it has stuck with you. I think you are a little hard on your newly minted third year self, who probably had no clue about what was happening or what should be happening. There were clearly many mistakes made along the way with this patient, and as you note, the VA is a special system within a system that is prone to such chains of shortcomings. I think what is commendable is that, lost and confused as you were, you still recognized the cold, even cruel (however unintentional) circumstances in which this patient learned he had cancer; and you were the one who reached out to him on a human level, assuring him there would be further conversation.

One of the things we have to struggle against in our interactions with others is attachment to our expectations of how things should go. The attending had a clear idea of what his goals were: evaluate the patient and present the plan. It seemed very hard for him to adapt this agenda, despite the fact that the patient was in a hallway waiting for an elevator; and later, despite discovering that the patient had no understanding that he might have cancer. This is why improvisational skills - knowing how to adjust to changing circumstances - is so vital! I wish this attending had paused long enough to find out what his patient knew about his disease; I wish he'd been able to acknowledge the patient's shock and fear. I wish he'd been able to offer support as well as information.

The purpose of a debrief is to process an event on both an intellectual and an emotional level, to understand more clearly what went awry, and what we can learn from it. The goal is not to blame or shame, but to learn from each other because we all make the kinds of mistakes this undoubtedly very stressed, burned out, overworked VA doctor made. I really respected that you, again as the lowly third year, recognized the value of this kind of reflection and will continue to push for it, not just for yourself but for the entire team.

10.12.21

Comment 1

This is such an interesting observation, Ruchi. We always say that in medicine, we treat everyone the same, but it is manifestly not so. When "no one wants to work" with a patient, their care will obviously be affected. It's such a good reminder that the intangible of interpersonal dynamics have a profound role to play in healthcare.

Comment 2

Great goal! He would be happy then he would treat staff better - then they would treat him better.

Comment 3

Just to clarify - listening is not the same as agreeing. You can always paraphrase the patient so they know you hear them - "it sounds like you feel this staff person has been very unkind to you" - and you can say "I'm sorry that's been your experience"; or you can push back a little and say "That's

interesting. I know they can be very kind with other patients. I wonder what's going on here that has made this an unpleasant interaction for you" - and this might lead into his own poor behavior.

Comment 4

Very ingenious! You found out what he wanted and were able to tie some of these things to what the staff wanted from him. It works with kids so why not with this patient?

Comment 5

And what you realize is that there's not always a magic bullet for bad behavior. Baby steps are sometimes all we get and then we just have to be grateful for those.

Comment 6

This is a tough realization, but a true one. We have limited ability to control others' behavior (we can't always perfectly control our own!). But the best chance we have to make some progress is to do exactly what you did - use the skills we know can improve things and hope they will have some effect (which they did in this case, just not the complete transformation you hoped for).

Comment 7

And I would have to agree. The most serious problems the patient had - the need for colposcopy and a highly suspicious bladder mass - could not be addressed. It sounds like these issues were prioritized in discussions with the patient, but that they were too scary or too overwhelming for him to deal with. When there are so many barriers, such topics can be hard to resolve in the in-patient setting. Ideally, if the patient had a continuity pcp whom he trusted, he could be engaged to pursue further work-up. My guess is that he did not have this kind of care and so, as you say, the end result is very frustrating.

Comment 8

the wisest - and saddest - thing you say in this essay is that we cannot control everything. It is obvious that you tried extremely hard with this patient to improve his situation and give him a better shot. And it worked - but imperfectly, so that while he agreed to some smaller things, the biggest issues were never satisfactorily resolved. This is usually the case in such a challenging circumstance - the patient takes baby steps and works up toward the big ones. But in an inpatient setting, there is usually not time for this to happen, especially since things do not always proceed in a linear fashion. There can be setbacks. As I note in the in-essay comments, if the patient had a trusted primary care doctor, this individual could do the hard work of calming the patient's fears and negotiating (just as you tried to do) a plan of care that would address colposcopy and possible malignancy.

You did what you could - indeed going above and beyond to try to find a way to reach the patient - and while not a failure, it did not result in the desired outcome. It is a hard lesson that we "can only do so much," but also a true one. You made a very significant and creative effort on this patient's behalf, but it sounds to me that he was simply not ready to take that giant leap into contemplating a cancer diagnosis. What we can always hope for is that your kindness and care planted a seed that will blossom in this patient in the form of greater trust and confidence in the healthcare system.

10.13.21

Comment 1

I am really touched that you stayed with her not for a medical reason but to "comfort" her. I suspect this is what she needed most.

The idea of involving the family was an excellent one. What might seem like bizarre ideation might also have some cultural roots that other family members could help explain.
Comment 2

I'm impressed at how hard you were working to try to figure out what the patient was trying to communicate.

Comment 3
Yes indeed. Those emotions (frustration, anger) would have been understandable with a frantic patient importuning you and grabbing you, but they would likely have simply escalated the patient's distress and out of control state. By choosing calm, you both retained better control of yourself and also were able to somewhat (not entirely) soothe her.
Comment 4
And this is excellent too, Shannon. From a place of (at least relative!) calm and centeredness you were also able to set some limits on the patient's behavior.
Comment 5
Agree. How fortunate you were able to involve them. From my understanding, this is also a culturally appropriate and sensitive approach.
Comment 6
Nice. So you had some outstanding role models who helped you maintain your own state of calmness and who didn't dismiss or judge the patient's behavior.
Comment 7
Great conclusion. This is exactly the balance to strive for - not tense, hostile boundaries, but compassionate, gentle ones. The boundaries can be the same, but the way they are presented will veel very different.
Comment 8
I really appreciated this essay. I appreciated your concern for your patient and your honesty about your own struggle with feelings of frustration and anger. I admired that you stayed the course; and that rather indulging those (very understandable) emotions, you used your excellent resident, fellow and nurse role models and your own commitment to patient-centered care to guide you. By staying with this patient, rather than abandoning her, by soothing her rather than judging her, you were able to somewhat deescalate the situation.

You also decided (wisely) to extend the system. Not every solution emerges from the medical team. Sometimes the best thing to do is reach out to others - whether these be family members, community or religious leaders, hospital chaplain, social worker etc. In this case, involving the patient's family had an immediately beneficial effect and also, in my understanding, was a culturally respectful step to take.

Finally, I really like that neither you nor the team jumped to the conclusion that the patient was "crazy." (I wonder if her insistence that she was "not crazy" stemmed from having already received this label from the healthcare system in a way that insulted and offended the patient). Of course, any patient of any background can have mental health issues. But we can be too quick to dismiss views

that have their origins in cultural practices as evidence of psychiatric dysfunction if we do not understand them. It was reassuring to see that the team kept an open mind.

I really loved your conclusion. It is not the case that being gentle and calm means going along with whatever the patient wants. Boundaries can be an important part of the therapeutic process. But how you set them matters. We can impose them in a harsh, judgmental, punitive way, which alienates the patient and harms whatever connection with the patient exists. But as you did, you can be "both gentle with listening but firm with action." This is a great insight, and beautifully expressed.
