Comment #1

Very tricky. The patient is an adult, but a fairly young one dealing with a difficult and recent diagnosis. The father may imagine he is being helpful; he may not trust his son to handle this situation on his own. Yet it is important to be able to engage the patient directly.

Comment #2

This was a good idea. Despite the difficulties the father posed, he is probably going to be part of the equation in treating this young man.

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Comment #1

Often, this term is used interchangeably with primary care; or is equated with treating all ages. But these days it is rarely understood in its true meaning, which has to do with treating the whole family not merely as individual members but as an interrelated unit. Great conclusion!

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Comment #1

good awareness of your emotional state. That self-knowledge is always helpful. For example, if you feel disappointed in someone, how might that influence your behavior toward that person?

Comment #2

True, but realistically culture is a complex and evolving construct, one that takes years to grasp even somewhat.

Comment #3

It sounds as though with many patients you've been very successful in helping to understand their medical condition. It's impressive to me that you have worked so hard to achieve this.

Comment #4

This reasoning is persuasive to the patient, so this is where a conversation needs to start. When a patient is resistant to acting in his own best interest, it means we have to better understand why. Maybe he is afraid. Maybe he thinks that not getting these procedures worked out well for everyone in his family, why should he jinx the trend? Maybe he felt he had as much on his plate medically speaking as he could handle, and just didn't want to deal with anything else. It makes perfect sense to "postpone screening for another day" so long as you have a plan for how you will continue to address this issue. You are looking for a line of thinking that will be compelling for this patient. As you've discovered, education is often effective. But sometimes other factors will override education. If you can figure out what these are, you can begin to move forward.

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Comment #1

These are very understandable feelings. Nothing can really prepare you for these early patient encounters.

Comment #2

As I'm sure you know, while most patients are accepting of medical students, and many appreciative, it is not unheard of for patients to vent their feelings of helplessness and loss of control, whom they perceive as relatively powerless and therefore a safer object for their distress than their "real" doctor."

Comment #3

Of course, being yelled at and called names is obviously unpleasant. Your feelings are completely normal. I think the next step to take, however, is to try to understand the source of the patient's anger. Not to excuse it, by any means; and it is perfectly appropriate to set limits on extreme inappropriate behavior. But in a way, such anger (so long as you are safe) is merely an opportunity to learn more about your patient.

Comment #4

This is a really empathic paragraph. Reflection often helps us understand a situation with greater nuance and complexity. All your hypotheses are possible (including the last one!). What you realized is that being ill can make people frightened and angry, and often those emotions come out toward the nearest available target. Thinking about what might be driving patient behavior is a crucially important first step. The next step is testing out your hypotheses by talking with your patient. "Help me understand why you're so angry." "Help me understand what you need from me." Beginning to understand your patient's story will humanize him, and will make your task of maintaining a "professional" demeanor much easier.

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Comment #1

This kind ROS can be frustrating, but it's worth thinking what it might mean that "everything" on the ROS is positive, that she has "pain everywhere," and that she cries easily.

Comment #2

Interesting example of "splitting" – you and your clinic will be the "best ever" doctors until you refuse to comply with a request, then you will suddenly become the "worst" doctors.

Comment #3

Lways frustrating for the physician. It's tempting to say, "The patient is whiny" or "It's all in her head." It's easy to be dismissive of such patients. We need to remember that they too are suffering.

Comment #4

,I would put it a little differently. Your feelings are your feelings, and annoyance is normal in these circumstances. The real question is, is this where you want your emotional response to the patient to stop? Do you want to let her know, in subtle ways, that you find her annoying? If, upon

consideration, you think this will not lead to your taking the best possible care of your patient, then you might think about how to soften this emotion to build greater rapport and trust with the patient (while not losing your boundaries, such as not giving disability to a patient you think does not qualify)..

Comment #5
I would say that boundaries are an essential part of the equation in successfully managing a patient with whom you have difficult interactions. But it is only part of the equation – the other part is listening, empathizing, and figuring out how to maintain concern for and commitment to the patient.

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Comment #1
I'm interested in your thoughts about the pros and cons of using a family member as the interpreter. Perhaps we can discuss this at our session.

Comment #2
This is a really well-written description that captures perfectly this "efficient" yet, from a relational, communicative perspective, somewhat problematic encounter.\

Comment #3

Indeed, I wonder what he thought of this procedure. Did he understand what you were doing? Did he give informed consent? Did he understand afterwards he would have painful lesions? Did he worry he had skin cancer?

Comment #4
You are sensitive to the fact that a lot was lost in this interview for the sake of efficiency. There is often a trade-off in attempting to deliver healthcare across language and culture, but it's very important to be aware of what you are sacrificing.

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Comment #1

I wonder if you considered asking the mom to step out of the room. Since she was your only source of information, that might seem paradoxical, but it might have changed the dynamics in the room and encouraged the patient to speak up.

Comment #2
Yes, that's a particularly distressing thought. Sometimes it is worthwhile to make a contract with a patient who worries you: "I know it wasn't easy to come here today, but I appreciate your making the effort. I'd like the chance to get to know you a bit more and talk further. Will you agree to coming back to see me again?" Even getting the patient to assent may increase the likelihood of follow-through.

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Comment #1
Interesting that she is willing to have premarital sex (also not approved by the Catholic Church), but not willing to use contraception.

Comment #2

Very interesting – if I understand you correctly, it sounds as though it was the trigger of the open-ended question that actually allowed her to probe more carefully than she had previously her own choices and the reasons she made them.

Comment #3

Sounds like a good compromise that respects the patient's interpretation of her religion.

Comment #4

This can be so hard – we love to tell people what to do, especially when we think we know best for them (and personally I agree with you that she is taking a significant risk that could jeopardize her entire future). But usually it is better, especially initially, just to listen to really understand the patient, and then and only then, you can explore what room for negotiation exists.

Comment #5

When a patient makes any decision – about medication, about contraception, about end of life – you want to respect that decision; and you also want to feel that the patient has made it from an informed and thoughtful place.

Comment #6

A good insight. When you tell people they are wrong, and they should adopt your way instead, this rarely is convincing. Instead it entrenches them more deeply in their beliefs and leads them to feel you "just don't understand" their perspective.

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Comment #1

Excellent, so you can see that from the patient perspective – and likely from the physician's perspective as well – this is a real victory, although it has not yet resulted to the desired outcome.

Comment #2

It is quite true that often patients who are embarrassed about their language skills speak English well. However, it is important to be aware that, even when someone speaks English well, they may be more comfortable using their native language, especially when discussing a sensitive issue such as health. Therefore it is a good idea to ask patients which language they prefer (if you have an interpreter or a blue phone available!).

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Comment #1

I'm curious – do you think this was your pt's basic personality structure; or was it influenced by past encounters with physicians and hospitals that had gone badly? (as above) Was it, in his eyes, a survival mechanism – i.e., constant vigilance to prevent some catastrophe?

Comment #2

Ah, this is very helpful information. If he is near the end of his life, then spending 21 precious days in the hospital must have been very disappointing. He must have felt very helpless.

Comment #3

I can certainly understand this, and although it was your "job" I still admire that you entered his room every morning.

Comment #4

At least he understood what you were feeling, although I wish that, based on his greater experience, he'd had a few more words of wisdom for you. When you feel like you want to get out of a pt's room as quickly as possible is often a good cue to sit down and take a little more time with that pt.

Comment #5

What happened here is that you took time to really listen and connect to the pt, and as a result he became a bit more "receptive"

Comment #6

This is adorable – what a great contract! You know, sometimes people employ pessimism as a protective strategy because they feel so out of control – "Oh, so I'm even worse than I was yesterday. No problem – I expected it." The challenge is to help the pt accept the uncertainty and "not-knowing" involved in a difficult medical course.

Comment #7

Brilliant – my guess is that this routine both showed your caring and helped him cope with his feelings of loss of control. As you put it, the approach empowered him.

Comment #8

And this is exactly what you did, with really impressive results. It's also worth noting that you had to overcome or set aside your own feelings of depression and frustration with this initially "difficult" pt in order to get to the bottom of his issues and provide him with the care he deserved.

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Comment #1

That was ingenious – it seems you were trying to teach her health literacy – indeed, just plain literacy – all in one fell swoop. It seems a lot to absorb, but the idea of practice was inspired. This might really cement the lessons you were attempting to impart.

Comment #2

Insightful conclusion. It is easy to blame the patient for "not caring about their health," but in many cases it is due to miscommunication and misunderstanding.

Comment #3

Indeed, it sounds as though you did. And I like the word "empowered." Not only did you instruct her, but you helped develop skills so that she could rely on herself. Excellent!

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Comment #1

That's an interesting response. No one likes changing their diet, but I'm struck that she started to cry. Was it because of her tears that you concluded she wasn't willing to change? I wonder what else was going on? Maybe this conversation needed to expand.

Comment #2

You found yourself in a very classical dilemma that I've also seen for many residents and attendings. You have ended up on opposite sides – you telling her why she needs to change, she saying she doesn't want to. This is an uncomfortable and frustrating situation, but there are (perhaps) ways out of the box. We'll discuss on F, but sometimes shifting the ground, talking a bit about her life, or how she spends her time, can help.

Comment #3

The key question is WHY. Is she feeling overwhelmed, depressed, fatalistic? When you can understand the reasons behind her refusal, you will be in a better position to help her.

Comment #4

This is a good idea too. Sometimes you have to deliver the same message many times before the patient can accept it.

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Comment #1

In the context of a multiethnic clinic, it makes sense not to make assumptions and ask every patient about language preference. Perhaps the “error” here is assuming that patients are either English-speaking or Spanish-speaking.

Comment #2

Exactly the right thing to do. You might have unintentionally made the patient feel uncomfortable or confused, so you apologized to her.

Comment #3

Insightful and absolutely correct. Unless you can tailor your knowledge to the circumstances of the patient, it is meaningless.

Comment #4

Excellent. By reversing roles, you acknowledge the patient’s expertise about her own culture. As you go on to point out, not only do you learn valuable information that can help you provide appropriate dietary advice, but you’ve succeeded in conveying interest in the patient beyond a diagnosis.

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Comment #1

What an interesting – and distressing – situation. It sounds as though, unlike Christian Scientists for example, she was not unwilling to have an extensive work-up, but she did refuse the “hand-out” of Medicare. I wonder if there was any flexibility in her position. If you call Medicare welfare (which I understand was her term, not yours), it sounds pretty patronizing and undesirable.. If you frame it as a society caring for its most vulnerable citizens who have already contributed to so much to the country, perhaps it becomes more palatable.

Comment #2

Of course you are right, and it should always be the patient's choice. I just think it's important to make sure that the patient is making a fully informed choice; and that their strongly held beliefs in fact are governing these choices. Some people's beliefs are more inflexible than others, and in my view it is legitimate to probe that line; and to seek for ways forward that do not compromise the patient's beliefs but may offer a "third alternative."

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Comment #1

Again, your suggestions are good ones, but you want to make sure that they are going to make sense in the context of your patient's life before you make them.

Comment #2

And now you got the story; now you understand the context. Now you've become the doctor that has earned those cookies!

Comment #3

Very nice. I agree, and this sense of belonging and being "home" will help you negotiate health care decisions with him and his family.

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Comment #1

This suggests she doesn't want to seem impolite by refusing, but probably will not be compliant.

Comment #2

Good for you for taking the time to ponder the patient's apparently inexplicable behavior.

Comment #3

Very well said. In a nutshell, this is what will determine whether the patient's care succeeds or not.

Comment #4

These are both excellent ideas. As you say, the first step is finding out in more depth why she is resistant to taking the medications.

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Comment #1

Very good. It's important to be able to adjust your "natural" style to meet the expectations and comfort level of the patient.

Comment #2

I like this a lot. I'd like to hear more about what you mean by a "compassionate inflection." It sounds like a lovely way of "softening" the interrogatory style favored in clinical practice.

Comment #3

Yes, sincerity is important, these emotions can't be faked. Sometimes nonverbals are more powerful than words.

Comment #4

What a lovely conclusion to this encounter. Both the patient's and the student-doctor's fears had been decreased. You were both more comfortable with each other. This is because a real connection had been made.

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Comment #1

This sounds like an incredibly frustrating experience, but it does make you appreciate the value of hearing the patient's story, and the importance of hearing that story from the patient him or herself.

Comment #2

It sounds like the patient had no or very limited language and no other means of communication.

Comment #3

I'm glad you wanted this personal input – it shows you realize good medicine cannot be practiced without the input of the patient!

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Comment #1

Of course you are right, it is very hard to witness patients unable to save themselves when you've provided the tools. In these circumstances, the only "tool" left is a relationship which can absorb disappointment and dishonesty. You can't build this in the hospital if he's lucky he'll have a pcp who does not enable but does not condemn him either.

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Comment #1

I’m interested in what you think are some possible responses when the patient is noticeably upset by the wait.

Comment #2

Sometimes a personal disclosure can show the patient that you truly do understand their feelings, and puts you on a more human level

Comment #3

Good for you – you are applying a painful lesson derived from your own experience to improve the experience of your patient.

Comment #4

It is so often the case that once you take the time to recognize the patient’s concern, and provide an explanation (not an excuse), the person feels heard and validated, and as occurred in this instance, the interactions proceeds more calmly.

Comment #5

Absolutely. The patient’s reasons will not always make sense to you, but they are always important to the patient.

Comment #6

Very wise. Placing yourself in the patient’s shoes is not always easy – nor even fully possible. But by making that effort, you will be much more likely to treat your patients respectfully and caringly. When patients feel seen, heard, and understood, they are more likely to trust their physician, and more likely to become actively engaged with their treatment plan.

Comment #7

Yes, as you hone your empathic skills, hopefully you won’t have to literally experience your patients’ suffering in order to be able to understand it.

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Comment #1

Indeed, a delicate and difficult situation. However, it is a myth that by asking questions about suicide, you will make it more likely for the patient to actually act on these ideas.

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Comment #1

This is what has been called a “surprise” in clinical medicine. It can be an unexpected lab result or an unexpected patient response. At this point, everything changed, and that means you have to change with it. Your old plan for managing the patient is out the window. New developments, new rules, new game.

Comment #2

And, with the help of your wise attending, you were able to adapt to changing circumstances, specifically by altering the treatment plan to take into account the patient’s level of distress.

Comment #3

Also good. As we discussed in class, you acknowledged the elephant in the room (his extreme distress) and by doing so, you got a much better understanding of where your patient was coming from.

Comment #4

I suspect this situation will have a positive outcome. You and your preceptor acknowledged the patient’s significant distress, negotiated a more acceptable treatment plan, stayed connected and offered support. Nice work!

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Comment #1

It may be that the resident, having little time, tried to set boundaries before the patient felt he was really heard. Also, as you saw, patients are very sensitive to nonverbal communication, which in this case perhaps seemed to contradict the resident’s verbal behavior.

Comment #2

This is an outstanding example of empathy. You tried to understand what might be informing the patient’s angry behavior.

Comment #3

Very well put. Finding out what the patient wants is not the same as giving the patient what he wants. But it is the basis for a connection and a dialogue.

Comment #4

Exactly. Underlying anger/rage is often fear. When you discover that to be the case, it may help in formulating your approach to the patient.

Comment #5

This is a great example of compassion-in-action. Not only did you take whatever steps you could to help him sleep, but by taking these steps you conveyed that you took his concerns seriously and would address them to the best of your ability.

Comment #6

This is of course a dilemma – who has 45 minutes to listen to a patient?! Two thoughts – with practice, you can in many cases reduce that time by half; and think of the time saved in dealing with his anger throughout the rest of his stay. It's very hard in the current medical system, with its emphasis on efficiency, to convince folks that taking some time at the front end saves time at the back end, but in my view it would be a better way to practice medicine.

Comment #7

Haha! That is hilarious. These "front desk" skills are really just basic communication and conflict resolution skills – which I predict will be some of the most valuable tools you have in practicing medicine.

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Comment #1

Hmm, so what would you say about this comment in terms of motivational interviewing? How motivated is your patient to change if he already feels he's doing "everything" he can?

Comment #2

How might your be patient feeling in response to this (very accurate) information. I imagine helpless, judged, inadequate. I wonder if there might be a way to "enlist" him in his own wellness. Maybe not, it is certainly a challenge.

Comment #3

A very nuanced insight, Avinash. I think we must have empathy for EVERYONE - the patient who

tries as hard as he (thinks he) can to worsening effect; the doctor who spends so much (apparently

pointless) time trying to help the patient; and the frustrated medical student who wonders what he's signed up for! ☺

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Comment #1

This is an interesting comment. Do you think that if the patient had more trust, he would have had the capacity to give you more feedback about his symptoms?

Comment #2

Even though his interest in baseball seemed irrelevant to the task at hand, I'm glad to see you spent a little time talking with him at this level. In a continuity care situation, this would probably be the key toward developing that elusive trust. However, given the patient's psychiatric condition, communication would likely always be challenging.

Comment #3

Very well put, and of course many patients fall into this category. It does make us grateful for the communication that we have available in most circumstances, imperfect as it is.

Comment #4

Indeed, it reminds me to appreciate how much the health care system relies on family members to help execute treatment plans. Although one person has a disease, it inevitably ripples out to the family.

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Comment #1

Thanks for making this point, Bianca. It shouldn't be necessary any longer to point out that "Hispanic/Latino" culture is neither homogenous or static, but unfortunately, it is.

Comment #2

Yes, as this insightful sentence illustrates, "noncompliance" is not a neutral term. It is also a judgment that the patient is "unmotivated" or "doesn't care about his/her health." These connotations provide a very easy out for the physician to, in turn, be "unmotivated" or "uncaring" about persisting to find ways to work with the patient.

Comment #3

Absolutely true. Eating is strongly influenced by family and culture, as well as peer pressure and individual psychological dynamics.

Comment #4

Very well said. It follows that, whenever possible, the doctor should not force her patient to “choose” between health and family, but should seek creative solutions that support the patient remaining within the important groups that provide them with emotional sustenance ☺

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Comment #1

Is this why you thought it would be a challenging conversation, because she seemed to be struggling so much?

Comment #2

What do you think her agenda was? To convince you that she was disabled by her health problems?

Comment #3

Wow. Bianca, this is not only a beautiful sentence, but incredibly insightful. I wonder where you can go when the patient is “consumed by her own internal sorrow”?

Comment #4

This must have been frustrating. I wonder whether this was the right goal for this particular session.

Comment #5

This is an interesting comment. What do you think made it so “exhausting”? Was it because you were frustrated that the encounter wasn’t more “productive”? Was it just exhausting to keep hearing her problems over and over?

Comment #6

Yup, it’s hard to get around this. Clinical medicine would be so much simpler if patients could just live simple lives

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Comment #1

So what do you think was going on? Is your patient drug-seeking? Is he afraid of additional pain?

Comment #2

This is likely the right approach medically. I wonder how the patient was feeling. Angry? Accepting? Do you think he felt he had a dependence or addiction issue? Do you think he will follow-up with the pain specialist?

Comment #3

This is probably one of the most important lessons of third year. As you go on to say, credibility depends not so much on knowing all the right answers (although of course we all want this) but trusting that this doctor will do everything in her power to find the answer; and if it's not found, then it doesn't exist. The main difference, I think, from the patient perspective, is whether they feel they are being brushed off or dismissed; or whether they feel that their doctor is working hard on their behalf.

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Comment #1

I respect your patience, Brad. It is so important to recognize the humanity of patients with dementia, and to accord them respect. It took you a lot longer than you might have hoped, but this is exactly what you did.

Comment #2

You know, I can imagine how distracting this must have been. Yet perhaps Mrs. X was trying to stay engaged, trying to participate. As you observe, it is a hard situation, but both you and your attending knew what was needed and you did it, despite the additional challenges.

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Comment #1

I'm very impressed at how this patient opened up with you. You must have done a very good job of creating a nonjudgmental, safe atmosphere.

Comment #2

As Dr. Khwaja commented, it is usually the primary care physician who diagnoses straightforward depression – not a psychiatrist. Sometimes the pcp is the only person the patient trusts enough to reveal their feelings.

Comment #3

Very good active thinking about your patient. You might well be right. The patient is certainly taking a big step away from her cultural and familial norms.

Comment #4

You are showing a lot of empathy for your patient, wonderful, it is very important to appreciate the patient's perspective and just how hard this is for her (as if struggling with depression weren't bad enough). As we discussed in class, identifying culturally appropriate community resources (which thankfully now exist in both the local Vietnamese and Hispanic communities) can go a long way toward supporting this patient on her path toward wellness. Ultimately, hopefully she will have the courage to share with her family what she is going through; and hopefully they will be able to offer support and understanding. It will be a journey.

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Comment #1

How creative. Rather than repeating the same dysfunctional pattern – explaining diabetes and its consequences to a patient who certainly has heard it before – this attending thought outside the box.

Comment #2

Nice interpretation. It may have been true as well that she was asking to be seen not only as a sick diabetic, but as this other person she still held onto in her mind and heart.

Comment #3

Absolutely agree. I wonder how you think what you learned about this patient might inform how you approached her lack of compliance.

---

Comment #1

Good point, although some patients are eager to help the med student along on his or her path; and many are appreciative when the student has time to listen to their stor (obviously not the case here).

Comment #2

Another great idea. You are acknowledging the patient as a person, and patients of all ages usually respond well to this approach.

Comment #3

You did everything right, but even so it is sometimes hard to win a patient's trust in a single visit.

Comment #4

It's great you have the desire to hone your skills in this area. Just wait till you get on Peds. You will have plenty of opportunity, and plenty of excellent role models!

Comment #5

These are all excellent ideas, and show evidence of creative, proactive thinking on your part. If the child is old enough and verbal, and you think is anxious about being at the doctor's, you can also address this directly: "Sometimes kids don't like going to the doctor. Is that how you feel? Is there something in particular you're worried about?" If you can elicit the kid's fear, you can find ways to make it less scary: "I won't do anything before telling you…" Sometimes it can help if you let the kid look at the stethoscope, otoscope, reflex hammer etc. first, and let them try them out on you!

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Comment #1

This is not an uncommon response. It is a very hard decision for many families not to take their mother or father home with them. There is often a lot of guilt involved.

Comment #2

Good for you. I can see you are absorbing as much as possible from your clinical experiences, and filing it away for later use. This is indeed an invaluable lesson.

---

Comment #1

Thank you for writing so personally. We forget that the physician's self-identified ethnicity, family, and personal history are VERY RELEVANT to patient care.

Comment #2

You'd be surprised – or maybe you wouldn't – at how often this issue comes up for medical students of various ethnicities, with patients expecting them to have a certain linguistic fluency.

Comment #3

As I'm sure you know, the emphasis on assimilation – including NOT learning the "old" language – was widespread in your mom's generation, and was intended to protect the children from prejudice.

Comment #4

How frustrating and disappointing this must have been. Do you think there might have been any ways to keep these lines open?

Comment #5

It may be that the patient is not so much disappointed that YOU do not speak Spanish as that they are anxious that there will be NO ONE who will understand them in their native language when they try to explain their symptoms. Being sick makes people feel especially vulnerable and out of control, and not having a common language intensifies these feelings.

Comment #6

I'm impressed that you noted, rather than ignored, this behavior in your patient because it gives you valuable (although uncomfortable) information about how the interview is going; and may help you try other approaches to gain the patient's trust.

Comment #7

That's wonderful, Brianna. A shared language helps, but even more important is acknowledgment of a shared humanity. You conveyed genuine effort and concern for your patient, and she reciprocated by (eventually) extending appreciation.

Comment #8

You state this extremely well. People can be patronizing, uncaring, and demeaning in the patient's language; and caring, commitment, and respect can be conveyed regardless of shared language.

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Comment #1

That is an understandable response. We all tend to avoid situations we think could trap us in a "briar patch."

Comment #2

I wonder if she perceives herself as the "health advocate" for her family, and if this is an important role in her own eyes and that of her family, so that she has to keep demonstrating it over and over again.

Comment #3

Unfortunately, this may have "rewarded" this demanding behavior, making it more likely that she will continue to use the same strategies.

Comment #4

You will not find explanations of her behavior that put her in a good light in your eyes; nevertheless, something is driving these actions, and understanding it will be important to care for her – or her other family members.

Comment #5

She is indeed manipulative and demanding – these are entrenched behavior patterns. The interesting question becomes WHY; and what is the best way of dealing with her.

Comment #6

This would be tempting on occasion – and of course, on even rarer occasions, doctors do "fire" patients, who are threatening or completely incorrigible – but overall, the nature of medicine is much more than a "customer service" where you can refuse people who are shoeless and shirtless (although it is often very difficult for "shoeless and shirtless" patients to find adequate healthcare). Everyone, even "difficult" people, deserve healthcare. And although I'm sure your attending was both experienced and skilled, there are many ways of working with such patients to make their care easier on everyone. While space precludes a detailed discussion, an approach that blends strong boundaries with sincere interest and concern can help.

Comment #7

I agree, these explanations don't make sense and are not satisfying because they are incorrect for this patient. She is not having a bad day – possibly a bad life; and she is not a patient advocate so much as an attention-seeking narcissist. She may even have a cluster B personality disorder. But this means that she has little control over her difficult behavior; and who will help her toward better behavior that doesn't alienate everyone around her if not her doctor?

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Comment #1

Great self-awareness Brooke. It's interesting how someone else's indecision – the lack of certainty in their lives – can unsettle us. It makes our lives harder.

Comment #2

Again, good awareness of your own judgments and biases. It's not surprising that you might have these reactions. How are they going to help you take care of your patient? If they aren't, is it possible to work with them (soften them, enlarge them)?

Comment #3

Another great question. You are questioning your own reflexive reactions, which is the beginning of figuring out how to work with them.

Comment #4

Who can be unbiased and compassionate all the time? No one I know. The key is to recognize when your emotions and cognitions are developing in ways that are disrespectful toward the patient and might subtly influence the quality of care she receives. No shame and blame, but with awareness comes the possibility of behaving in somewhat different ways.

Comment #5

And all I'd add is learn how to forgive yourself for mistakes – because you will make plenty of them! – but only after, as you have done so impressively – you've put attention into learning what they have to teach.

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Comment #1

Hmm, this is a puzzling response which I'm not sure I understand. Was she saying that she felt it was unfair for her to have to spend money on medications? Did she feel if she spent this money, she would not have enough resources to invest in her appearance? I have trouble accepting this at face value.

Comment #2

Ah, this is a helpful explanation, thank you. So the idea is an emphasis on the present moment, rather than long-term consequences? Also, possibly the desire to appear prosperous and doing well? I agree with you that this has little to do with African-American culture and more to do with SES.

Comment #3

Excellent, Bryan. You are trying to see this apparently irresponsible decision from the perspective of people living very different lives that embody different priorities. This is true empathy.

---

Comment #1

Again, fortunately patients are not usually so rude, but it does happen. I wonder if you have any thoughts about why this particular patient was so upset.

Comment #2

You handled this situation very well. You were not defensive, and you provided the patient with a reasonable explanation. You did not disclose that actually you were in a difficult situation by having to check on the patient without knowing anything about them.

Comment #3

Good self-control. I think anyone would feel like losing their temper in these circumstances; yet as you realized, the focus still needs to be on the patient.

That being said, it seems to me this patient was being verbally abusive. This is not appropriate behavior, even when someone is upset or scared, and it is perfectly within your role as a third your student to request that the patient not use abusive language toward you.

Comment #4

Nice work, even better than my suggestion above! You met the patient where he was – wanting to move things along – and helped him understand the best way to accomplish this goal.

Comment #5

Under these circumstances, providing the patient with honest feedback, and explaining once again how it is working against what he wants, is very reasonable.

Comment #6

It is perfectly appropriate to set a limit on a patient's rude, abusive, or even dangerous behavior. It's worth practicing doing this while KEEPING your composure. In other words (and believe me, I understand this very well), we can have a tendency to fuel our discomfort at setting a boundary on a patient with our own negative emotion. This is not actually necessary (although it's hard to avoid). Just a suggestion.

Comment #7

This is a true observation. It is also true that while you cannot leave as the physician, you can act in ways that tell the patient you are angry. This is not ideal. Better is to focus on the anger, let the patient vent, keep breathing, and see if you can de-escalate the situation (as you did very well at the beginning of the encounter). You can also set boundaries (as above) – for example, saying you're going to step out for a couple of minutes to allow the patient to calm down, and start again. Of course, you can dismiss a patient from your practice if such behavior is habitual. However, in most cases, the patient is simply afraid or very stressed; while I agree this is not an excuse for bad

behavior, sometimes the physician has to be the bigger person, and give the patient the benefit of the doubt.

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Comment #1

Excellent observation of your patient. You clearly paid very close attention to all aspects of her physical presentation.

`Comment #2

With this patient, there is some evidence of splitting, common with people with borderline personality disorder. Doctors are either “good” (when they give the pt what they want) or “bad” if they attempt to set limits. At this early point in the encounter, it is probably best, as your attending did, to remain nonjudgmental and just listen, making no commitments or promises that might need to be renegotiated when the situation becomes clearer.

Comment #3

Here I believe you are making an excellent point. Without emotional connection, there is almost no likelihood the patient will even consider limits or change. Therefore, the most effective stance not only for the medical student but for the physician is to be AWARE of the pitfalls of emotional engagement WHILE SIMULTANEOUSLY seeking appropriate ways to have concern for the patient – who certainly sounds as though she needs it.

Comment #4

You are asking great questions; and as you surmise, there are no easy answers. Addiction really complicates the doctor-patient relationship, because the craving for the drugs usually trumps the commitment to the relationship. In my view, the attending handled this situation with great skill. It is unclear whether, given her physical dependence on these drugs, it will be possible to reduce the dosage or even wean her. Your attending is looking for a way to move forward with the patient that is within ethical boundaries yet protects the life of his patient.I agree with you that the chances of succeeding with this patient are slim. But your attending is taking the first steps toward trying. I respect him for that effort.

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Comment #1

This seems a rather unpleasant stereotype. I think there can quite a bit of suspicion from Roma toward mainstream society; and as a result, they can tend not to divulge personal information, but I would hesitate to call this lying.

Comment #2

Really like this last comment. It shows that you are ready to work with your patient's cultural sensibilities in order to find common ground. Very nice!

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Comment #!

you are making what should be an unnecessary but often still needed observation that "not all Asians are alike." You have very different linguistic, cultural, and personal backgrounds. Yet you also recognize certain shared commonalities. Recognizing clearly areas of overlap and of difference is important in providing good patient care, so that you (or more likely others) don't make mistaken assumptions.

Comment #2

That's lovely role-modeling on your preceptor's part. It seems as though not only you, but your preceptor as well, was paying careful attention to the patient's nonverbal cues.

Comment #3

It sounds as though there was a lot of successful nonverbal communication occurring between doctor, patient, and spouse in this encounter, and that this mitigated the pain and fear of the situation.

Comment #4

So well said! "Just by reading the room…" Many physicians ignore this vital source of information. As you say, you can pick up valuable clues to the patient's mood, and adapt your interaction accordingly.

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Comment #1

Interesting – did this experience help you understand how best to approach your patient? Did the father/teacher make any suggestions for how to conduct the interview or exam?

Comment #2

I admire your enthusiasm for a challenging patient encounter. Maintaining this attitude can help you find other sorts of difficult encounters to be interesting learning experiences rather than something to dread.

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Comment #1

I wonder how you would handle this refusal? Would the sex of the examining physician make a difference? Was there room for negotiation?

Comment #2

Did being blind play a role in her healthcare in any way? Did it affect your interaction in any way?

Comment #3

I appreciate your recognizing that you hold a certain stereotype – as do we all. I'm curious about what that is.

Comment #4

This is a really insightful comment. Excellent! In this case, Islam may have (we don't know for sure until we engage the patient on this topic) given your patient a different and more positive identity.

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Comment #1

Hmm, I wonder how he reconciled this discrepancy. Most recovering addicts are paranoid about receiving narcotics, even when their pain is intense.

Comment #2

This is also interesting. Did the attending believe the patient was in severe pain, or was this simply the easiest path to follow?

Comment #3

This must have been so discouraging for you. Patients with drug and alcohol addictions are some of the most difficult to treat – and frankly are the most loathed category of patients. The dynamics of drug-seeking – and physicians' reactions to be manipulated and/or abused – do make it very challenging to care for such patients. I'd be interested in your thoughts about how to best manage such situations. We will discuss this in the session as well.

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Comment #1

One of the problems with members of the dominant culture is that they tend to see themselves as “normative,” as having “no culture.” Thanks for pointing out that this is not the case.

Comment #2

Really good observation skills, you’ve already formed a hypothesis about this relationship before a word has been spoken. Of course, as with all hypotheses, we always hold them lightly and constantly look for confirmatory or disconfirmatory data gleaned from the subsequent interaction, collateral sources etc.

Comment #3

This is a common strategy in addicts. It may be related to the parenting they received, but it is also related to their personality structures and their need to protect their habit.

Comment #4

This was a great idea on your part, to try to shift the daughter-mother dynamic and reframe the issue. Instead of an inadequate, enabling, indulgent mother, you presented an alternative view of her as loving. This provoked a shift in the daughter from blame to respect. Whether that single intervention was sufficient to turn the tide is uncertain, but simply by giving the patient another way to think about both her mother and herself, you may have introduced an important motivator for change.

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Comment #1

As we discussed, for a variety of reasons, this is a very common response in patients. Getting patients used to the idea of insulin is a process

Comment #2

I can well believe this. It would be interesting to know what approaches your preceptor had tried. As we mentioned, creativity is an important part of clinical care. When a perfectly sensible, logical approach (say education) is just not working, challenge yourself to think of a different way to present the issue.

Comment #3

Great attitude, I really admire this. It is often quite effective. But even when it's not, I think it's still the right attitude. Just like any challenge, you may not master it the first try. But you can come back and try again.

Comment #4

This suggests to me that the patient may associate insulin with decay and death, certainly not a connection that would make him want to take insulin! If this were so, then one challenge becomes how to change his thinking on this point.

Comment #5

If a patient is really ready to accept a premature end of life, the physician must accept that. But I don't know that I would take this at face value. Based on some of his other disclosures, I suspect he is simply afraid of what would happen should he start insulin.

Comment #6

It is a lot easier to come up with alternatives in retrospect, or as we did today, with an excellent braintrust. As you become more experienced, you will develop more arrows in your quiver. And depending on the specialty you choose, you may have the opportunity to come back to fight another day

Comment #7

Often, understanding the medical consequences of a decision, as important as that is, is only the beginning of the conversation

Comment #8

Of course you do, this is perfectly natural, and how every doctor feels. You go into medicine to help people and make things better for them, and it is discouraging when beneficial courses of action are available, and the patient resists taking them. If you think you have failed, there is a tendency to blame the patient or abandon them (at least emotionally). Instead, congratulate yourself on a great effort, and learn what you can for next time. As you point out in your final sentence, perhaps the most important thing is that the patient keeps returning for care. There is a part of him that is asking for help; and every time he shows up in front of you, there's a chance you can give it.

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Comment #1

Both interesting and VERY frustrating. One key question is whether this is really an "informed" choice, or a signal of hopelessness and desperation.

Comment #2

Although you are absolutely right that diet and exercise eventually are precisely what needs to happen for this patient, I wonder at this point whether such counseling makes much sense. What is going on with this patient? Why is he denying his illness? Why does he say he'd rather die than eat healthily? There are some basic questions that probably need to be better understood before plunging ahead.

Comment #3

You know, it is very easy to conclude that the patient "doesn't care" about his or her health. In my experience, I've discovered that often, although it "looks like" not-caring, the patient is closer to anger, helplessness, fear, despair etc. In other words, there is a part of them that wants to get better, but they don't believe they can.

Comment #4

Yes, your agenda (and your "task" per the attending) was to do an f/u diabetes interview. But this agenda had very little to do with where the patient was, which is where the doctor must always start.

Comment #5

This is an interesting perspective. I'm not sure I entirely agree, but I'd like to understand it better. Perhaps the word "diabetes" frightened the patient, which is understandable. However, I find it an odd concept to treat a patient for a disease the patient doesn't believe he has.

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Comment #1

Again, good awareness of your own emotional response. This is a very normal and common reaction to a patient for whom there is no clear path forward. Awareness of our own emotions is important because they can subtly influence our behavior toward that patient. For example, when a patient makes us feel hopeless, it increases the likelihood that we will withdraw from that patient or punish them in some way. Awareness can counteract these anti-therapeutic tendencies.

Comment #2

Brilliant reframe! (Dr. Kilgore is indeed an amazingly skillful physician). What a great approach – acknowledging all that the patient had endured and reconceptualizing her life as one of resilience and survivorship. Rather than focus on the deficits, which were very apparent, he emphasized her strengths, and as you insightfully observe, rekindled the patient's hope.

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Comment #1

Very good insight, Christy. I agree it is a stereotypical approach that sends a very poor meta-message ("all you people eat lots of tortillas").

Comment #2

Excellent! You can get the needed information without making assumptions or conveying that you see all Latinos as "alike."

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Comment #1

This is a very frustrating situation, but at this point there are few options. Ideally, this issue might have been raised with the pt during routine ob care. "What will you do if there are no female ob-gyn docs on call when you into labor?"

Comment #2

Wow. Unfortunately, this couple – or at least this husband – has very strong feelings on this point. That would make it especially important to discuss the issue in advance, as it could literally become a matter of life and death for the patient.

Comment #3

This raises the very intriguing question, what do we consider a reasonable request? Is refusing blood products (most Jehovah's Witnesses) a reasonable request? Is demanding a physician of a particular race a reasonable request? Is refusing certain foods reasonable? It's worth examining our basis for making these judgments.

Comment #4

excellent work here in considering different possibilities to explain his behavior, because of course we don't KNOW what was in his mind. But pay attention to how the "story" you tell about the husband changes the way you feel toward him: If you say he is "entitled," it probably brings up certain feelings; if you say he is "protecting his and his wife's deeply held religious beliefs," you may feel another.

Comment #5

In our culture this behavior would be considered controlling, perhaps even abusive. However, in other cultures, it would be considered normative. That does not make it “right,” of course. But it reminds us that people usually act within their own standards of what is right and wrong.

Comment #6

I agree with you. Like you, and I’m sure everyone else involved, including the patient and her husband, I was relieved to know that the delivery proceeded without complications. But as you realized, it might have gone another way. Perhaps, faced with that dreadful situation, the husband would have relented. Perhaps the patient would have agreed to be seen by a male physician (if she were able to consent). Perhaps doctors would have intervened regardless of patient and husband’s wishes, arguing that their responsibility was to save the life of the infant. But the main point is that none of this should have been left to an emergent situation in which emotions were already running high. In all the prenatal visits that preceded this delivery, perhaps the most important piece of information was this family’s views of the gender of the delivering obstetrician.

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Comment #1

As she should be, it’s so exciting to see this kind of change. I hope you let her know how impressive these changes were.

Comment #2

Such an important insight. We assume these choices are “individual,” but very often they are mediated by cultural, familial, and social factors.

Comment #3

Good awareness that your experience in this case is very different from your patient’s. It’s easy to project your perceptions and assessment of a given situation onto your patient (“I choose my own diet, it’s all under my control, she should be able to do the same”). In this case, you realized that your relationship to healthy eating in fact was quite different than that of your patient.

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Comment #1

Again, these are all good thoughts. Any or all may be contributing to this particular patient’s refusal – or something you and I haven’t thought of yet!

Comment #2

Again I agree – I'd be interested to learn in what sense this encounter helped you to examine YOUR cultural beliefs and biases – about Hispanic patients? About women patients?

Comment #3

Good insight – understanding the patient is one waythat rather amorphous concept of "respect" is translated practically.

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Comment #1

What a wonderful insight! You are finding the key to maximizing your effectiveness with patients (which IS limited).

Comment #2

You know the saying, the perfect is not the enemy of the good? It strikes me that your patient and you both were working on the same lesson – to accept limits and imperfections, to acknowledge small victories, and to stay the course. I'm impressed with what you learned from this patient. Congratulations!

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Comment #1

I love the way you juxtapose "pleasure" and "odious" in the same sentence. The irony signals that this is going to be a challenging patient encounter.

Comment #2

Of course, sometimes it is harder to acceptan outstretched hand than it seems. All sorts of things get in the way – mistrust, pride, depression, testing the physician's commitment and many more. A skilled physician learns how to keep offering that hand until it is accepted.

Comment #3

Mr. T definitely sounds angry. Apparently, he is in so much distress that he has lost most of his social graces!

Comment #4

When a patient is so obviously angry, sometimes the only thing to do is acknowledge the anger. I wonder how you might have done that.

Comment #5

Ouch. I wonder how this cruel comment made you feel. Were there daggers in your "silent stare"? Were you resentful to be abused in this manner? Were you glad you'd never have to see Mr. T again? Did you feel that you'd failed him? This was a very difficult interaction, but there's a lot to be learned from it.

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Comment #1

Indeed, the quantification of everything seems to be the ultimate goal these days. Know the famous phrase, often attributed to Anais Nin: "Not everything that counts can be counted."

Comment #2

Perfect ending, full of humility and a bit of humor, both necessary qualities to survive medical school – and medicine!

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Comment #1

Yes, "Hispanic" culture is by no means homogenous or static, and takes many different forms that are constantly evolving and changing.

Comment #2

This does sound very frustrating. You have all this knowledge about how to improve the patient's health, and she rejects it. On the other hand, I wouldn't be too hard on yourself. There was a big gulf between you and the patient, and it would probably take more time to search for common ground.

Comment #3

I'm impressed. This is a good beginning. It is worth noting that, despite her resistance to medication, she WAS in a medical clinic, which suggests she must have wanted SOMETHING from western medicine. That also might have been a place to start – what did she hope for from her doctor?

Comment #4

Excellent observation. There's a desire to be as efficient as possible and do everything for the patient's health at once, but in this case baby steps are probably going to be necessary.

Comment #5

I certainly agree. It can also be true, however, that when you approach these situations with curiosity, interest, and an eagerness to include the patient's perspective, they become a bit less exhausting and overwhelming.

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Comment #1

Good observation on your part. You didn't rely entirely on the patient's verbal assertions. How could you have explored this sense you had with the patient?

Comment #2

Yes, his physician can't tell him not to make the trip, but he can urge caution, and express hope for the patient's safety.

Comment #3

Absolutely. An excellent insight. You realize that cultural, familial, and societal forces exert influences on patient's health that often are beyond the physicians control.

Comment #4

Very much so. In another type of patient-doctor relationship, the patient might not even have disclosed this intended trip.

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Comment #1

This is why medicine cannot be standardized. It is part science, but definitely part art. Each encounter in some respects is particular and unique, even for patients who have the same diagnosis. As Osler said, it is not as important to learn what disease the patient has, as what patient has the disease.

Comment #2

Ouch. This is rather insulting logic. Is respect supposed to be based on how much money you have? It would be hard to remain calm and caring in the face of such a comment. I wonder what might be

going on with this mom. Maybe she is used to having control of things because she is wealthy and competent, and it is scary for her when she finds things she can't control, like her daughter being sick or having to depend on doctors to help her.

Comment #3

Your attending seems to have identified the root misunderstanding. The mother interpreted the lateness as disrespect, whereas clearly this was not the doctor's intention. Clarifying this might enable to interaction to move forward.

Comment #4

No perfect solutions – sticking to a schedule is not the most important thing; but it is also true that accommodating one patient often means inconveniencing others. Most good doctors I've seen make this decision on a case-by-case basis.= - how sick is the patient, is being late a pattern, how quickly can the problem be addressed etc.? Sometimes the MA can give waiting patients a heads up that the doctor is running behind. If patients feel their doctor will give them the time THEY need, they are often willing to wait for him or her.

Comment #5

There are many, many aspects of medicine that are not predictable. It is an important skill to learn how to deal with uncertainty and ambiguity, since clinical medicine is not as controllable as say, bench research ☺

Comment #6

Again, good comment. I'd agree, in these circumstances, the goal was to defuse the anger, so the more important goal of examining the patient could be achieved.

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Comment #1

Dawn, this is really eloquent… and describes, at least in my understanding, exactly what they are trying to do.

Comment #2

Again, an absolutely beautiful phrase that captures perfectly what these tattoos once meant to this man.

Comment #3

Dawn, you tell a moving story with great skill. This is a narrative of new beginnings and hope.

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Comment #1

Good points – while it is helpful to learn as much as possible about other cultures, at all costs we must avoid stereotypic generalizations. People are members of cultures, but they are also unique individuals.

Comment #2

This is a great point, Debra. In this country, we are very uncomfortable talking about class. But obviously ses differences exist, and they can determine such things as, for example, what foods are available for purchase.

Comment #3

Residents and attendings sometimes avoid using interpreters because this process takes longer. However, cutting corners in obtaining the history and counseling the patient is risky and can often have unfortunate consequences. Every patient deserves to be able to have good communication with their physician.

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Comment #1

This is certainly a strange pattern. Were you able to learn anything else about her lifestyle? School? Job? Family/friends?

Comment #2

I can understand your reaction – she is taking time away from someone who has “real” disease. But perhaps you can consider her visit as a cry for help. Something is surely amiss that might explain her peculiar habits.

Comment #3

This impulse seems natural; yet the fact that you didn’t actually tell her this suggests you could anticipate how this might have a deleterious effect on your relationship with your patient.

Comment #4

That’s okay. I appreciate your honesty. There are plenty of patients who do not instantly evoke compassion in caregivers. The trick is to learn how to move beyond irritation, aversion etc. and become curious about the patient before you. Compassion is often a by-product of understanding (not necessarily approving of) the patient’s story more deeply.

Comment #5

Nice work, Derek. You went beyond your initial reaction to acknowledge the complexity of the patient’s situation, and why it was not so simple for her to go into the world.

Comment #6

Excellent insights, both that “it’s not a crime to feel frustrated” AND that it’s important to go beyond reflexive emotions to reflective analysis. If I’d bothered to read your essay through to the end before commenting, I could have save myself some work! ☺

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Comment #1

Good sensitivity and observational skills on your part. You did not pretend, as some do, that nothing was going on.

Comment #2

Again, excellent Ian. This is the patient’s agenda – what she wants done, what her expectations are. Knowing this is essential in negotiating a successful dr/pt encounter.

Comment #3

This may well have been the case. As we discussed in class, sometimes pts are concerned they are getting second-class care when a medical student walks through the door (of course that’s not true!). I really how actively you were thinking about what this patient was thinking and feeling. Of course, the best way to test such hypotheses is to ask the patient. “I wondering if you have any concerns about the questions I’m asking.” “Sometimes pts worry when a medical student like me sees them. Are you wondering about anything I can help explain?”

Comment #4

Nice work – you established common ground with the pt (both of you wanted to treat the rash), and showed her explicitly how your questions could help accomplish this goal. In this way you reconciled your agenda with hers.

Comment #6

Very nice – you are thinking about how this pt encounter can inform future patient encounters. By being transparent with the patient about why you are doing what you are doing, you will reduce the gap between her and you, and make it easier for the two of you to understand and appreciate each other.

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Comment #1

Yes indeed, this can be very frustrating for the physician. Why is the patient here if she doesn't bother taking responsibility for her behavior? How can you work with these excuses in a way that might move the encounter forward without shaming and blaming the patient?

Comment #2

Excellent observation about your patient. How might you have been able to use this to change the dynamic and addres the issue of excuses more directly?

Comment #3

I'm glad to hear the patient agreed to follow through on the plan. I wonder what might have changed for her (as I imagine as an addiction counselor she is well aware of where her drinking might lead) that she now felt ready to commit. Do you think she was motivated by fear?

---

Comment #1

Excellent that you elicited this information. It makes sense why he would not be "motivated." His job and lifestyle may make it seem overwhelming to tackle his diabetes.

Comment #2

Also interesting and important information. I wonder if his physician has discussed this lack of change with the patient.

Comment #3

It is humbling to realize that physicians have limited influence on their patients. Still, physicians can exert a powerful effect on their patients' lives. In this case, that may not be possible. But I've seen patients in similar situations where their physicians have been able to work out lifestyle compromises that have improved their health. So it is always worth considering if any stone has been left unturned.

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Comment #1

Very impressive, Kiran. Many people, including experienced clinicians, choose to ignore these very obvious cues, and pretend everything is fine. By confronting the situation directly, you forced the pt to take responsibility for his rude behavior.

Comment #2

It looked like your strategy worked. Sometimes you can also ask the pt what is going on: "You seem upset with me. Have I done something that bothers you? Can you help me understand what's going on?"

Comment #3

Indeed, it appears that by bringing the patient's behavior to his attention, you helped him reevaluate and even apologize. Good work!

Comment #4

Honestly, I think in the 21st century, there is less likelihood that this will happen, but it is a possibility under certain circumstances.

Comment #5

Unfortunately, these are some of those circumstances! Certain cultures do still hold a restrictive view of women's abilities and appropriate roles. Sometimes these are negotiable with the patient, but sometimes not.

Comment #6

The answer to this is probably no, because unfortunately there is no one right way to approach patients. The important thing is to have several "arrows in your quiver," so if one approach doesn't work you can try something else. Direct confrontation, in my experience, is most successful when it comes from a calm, compassionate (as opposed to anxious/hostile) place. When the pt senses you truly have their best interests at heart, it is surprising what they can absorb.

Comment #7

I wasn't quite sure what you meant by this last question. Are you wondering if better educated patients, being more similar to their doctors (at least on this dimension) have better pt/dr relationships and are more compliant? I'm not aware of any research supporting this. I suspect that other qualities and characteristics are more significant on both these dimensions of relationship and compliance.

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Comment #1

Healthcare involves so much more than the biomedical. The medicine is complicated enough, but often it's just the tip of the iceberg.

Comment #2

It's great she had enough trust to disclose this to you, but how tragic that patients in the US have to struggle with such dilemmas, in addition to their actual disease!

Comment #3

It is not impossible to try to find at least partial solutions for this patient on an individual basis, but of course the real solutions are not individual but societal.

Comment #4

As you likely suspect, merely encouraging healthy behavior probably will not have much of an effect given the constraints under which your patient is operating.

Comment #5

This is very honest on your part. I agree – you (and I too) cannot imagine this woman's life. But by trying to see the world through her eyes, you may be able to better work with her to find solutions.

Comment #6

This was a creative idea, nonetheless. It shows you were thinking proactively to find an approach that would be compelling for your patient. This is what good patient care is all about.

Comment #7

Sadly, it is true that there is only so much you can accomplish in a 15 minute encounter with a stranger. Even with more time and more contact, the medical system cannot solve all the social injustices that surround us. Nevertheless, it is worthwhile to consider what CAN be achieved: 1) You

can listen to her story with respect and interest, even if you cannot fully comprehend it 2) You can express admiration and respect for how well she's contending with repressive and overwhelming forces in her life. 3) You can let her know you have sincere concern for her wellbeing and want to help. Basically, you can start to build trust and to plant the seeds that she has overcome many challenges in her life and you are there to partner with her to overcome this one. If you're very lucky, she'll come back. If you're lucky, she'll remember some of the things you told her when she sees the next doctor. And in the interim, you can advocate for universal health care or whatever reforms you think are just and equitable.

---

Comment #1

Yes indeed, I think your feelings of frustration with patient noncompliance are widespread among physicians. It is almost as though the patient is undermining what you've dedicated your life to doing.

Comment #2

That's because there is no "correct answer." This is what can be so challenging about clinical medicine – it is an unpredictable exchange that happens between two people. I would suggest that "noncompliance" should always be the beginning of the story, never the end.

Comment #3

I'm not sure that I agree that the core issue here is patient autonomy. This assumes that the patient is freely making choices after a well-reasoned process of analysis. It may well be that it is less about the patient exercising autonomy than the result of many other socioeconomic and cultural forces that contribute to the patterns you observe. In terms of your statement about "grasping the gravity of the situation," how might you be able to determine this?

Comment #4

Is the goal for you to accept the patient's noncompliance? I wonder whether, by understanding what underlies her apparent "indifference," you (or more realistically, her physician) can begin to identify different approaches that might be more successful in engaging the patient.

Comment #5

“Scolding” is a double-edged sword. Occasionally, it is a successful strategy, when done within the context of a trusting doctor-patient relationship; but most of the time it comes across as patient blame and is rarely effective in changing behavior.

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Comment #1

Do you agree with your resident? Should he or shouldn’t he have said this? What is the value of sharing these feelings? What is the potential downside?

Comment #2

Your observations about the boyfriend are very nuanced – both his immaturity but also his knowledge and his pride in that knowledge. It’s valuable to see both, as the former may impede his ability to parent, but the latter may provide a basis for responsibility.

Comment #3

What are some of the important follow-up questions to ask in a situation of suspected dv? For example, some people might not consider shoving or grabbing physical abuse, but it is. A pattern of intimidating, controlling behavior is also indicative of abuse.

Comment #4

It is very hard when we think patients are making choices against their own self-interest. Yet these are choices that must be accepted, unless there is evidence of immediate threat to the patient.

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Comment #1

Do you agree with your resident? Should he or shouldn’t he have said this? What is the value of sharing these feelings? What is the potential downside?

Comment #2

Your observations about the boyfriend are very nuanced – both his immaturity but also his knowledge and his pride in that knowledge. It’s valuable to see both, as the former may impede his ability to parent, but the latter may provide a basis for responsibility.

---

Comment #1

It doesn't seem to make sense, does it? From the patient's perspective, how might these things seem more significant than the possible negative outcomes she faces? Could it be that these are discomforts she experiences on a daily basis, while the "big ones" are still just hypothetical?

Comment #2

Your patient also holds the belief that God will protect her, so perhaps she didn't have to take care of herself. I wonder if there was any way to tie her religious beliefs to her health care?

Comment #3

You're right, it's quite a dilemma. Yet your patient is there, in the clinic, which means she must have some faith in medicine as well. Again, how could you bring these together? If her child were sick, would she simply trust in good or would she take him to a doctor? Could God be taking care of her by bringing her to the doctor and by wanting her to listen to the doctor?

Comment #4

Very well said, Chirag. I think you are beginning to realize that patient education is a lot more than just "informing" the patient but rather eliciting then working with their fears, beliefs, and values, seeking to find common ground between your views and theirs. You are on the right path.

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Comment #1

This is important information, perhaps it represented a starting point. It would be interesting to understand a) why he keeps coming back and b) what could happen that he would consider "helping him"?

Comment #2

Honestly, I would have advised the same thing! In interacting with other people, there are no guaranteed strategies. It helps to have lots of arrows in your quiver! I'm sorry this one didn't find it's mark.

Comment #3

You have probably already been counseled on this issue, but your commitment to the patient certainly does not extend to putting yourself at risk. If you feel threatened, you can take precautions such as sitting near the door; asking your supervisor to accompany you; or even call security.

Comment #4

This is an understandable and appropriate expectation, but not all patients will meet it. Of course, you still have an obligation to care for hostile, uncooperative, and otherwise unpleasant patients. But the more you can win their trust and understand their anger, the better care you will be able to take of them.

Comment #5

I really like the fact that you are thinking about what you can learn from this interaction. In this case, you gave the patient an opportunity to tell you why he was upset, and I think this was an excellent approach, even though it was unsuccessful. You could not assume he was mad about waiting unless he told you so.

Comment #6

Okay, so this is some information you managed to extract. At this point, paraphrasing can be helpful: "It sounds like it is very frustrating for you when we refer you to another doctor. Am I understanding you? I'm so glad you've let us know that." Once your patient feels heard and understood, you can move on to negotiating the need for referrals.

Comment #7

I can certainly understand how this feeling arose, given the patient's hostility. Of course, it is also true that this is one patient; and I'm pretty sure if I asked you you've had more positive experiences where you've made a difference. Although these interactions feel very personal, sometimes it helps not to take them too personally; but to consider the possibility that you are just a convenient "target" for issues that may have a long history.

Comment #8

All good points. In addition, because you are a medical student, patients may find you less intimidating and relate to you more easily. You may not have experienced this yet, but many patients will see you as their advocate, as the person who really cares about them in this bewildering health care system.

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Comment #1

Janice, I admire that you persevered with this routine every day. This was the right thing to do, despite other patients rolling their eyes. You were humble, respectful, and determined to maintain some sort of connection.

Comment #2

Did I mention humble?! You've demonstrated a very wise lesson – your response to your patient is not determined by the patient's behavior. Good for you for persevering in your approach. The fact that he has an underlying dementia may partly explain his rude behavior. He may also have been feeling extremely frightened and disoriented.

Comment #3

There is always a "reason" behind patient's anger or rudeness; and if you take the time to figure out what it is, you will probably get farther with the patient. I'm not saying this kind of behavior should be excused, but it should, if possible, be understood.

Comment #4

This is an important lesson – very often the patient's behavior is less about you, and more about their circumstances and their suffering.

Comment #5

I might amend this slightly to say, don't allow negative emotions to REFLEXIVELY guide your efforts. Your emotions can be a cue that something is amiss in the situation; and can point you in the direction to try to better understand the problem.

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Comment #1

I think you may have felt this sense of responsibility because you have started to identify with the medical profession as a whole. Obviously you were not connected in any way to this incident, but you are becoming a member of a group, so that you rejoice in their triumphs and cringe at their errors. As well, you are paying attention to what happens to patients within your profession, and are trying to learn from both positive and negative examples. I find that very commendable.

Comment #2

Very well put, Michelle. Neither doctors nor patients are perfect; and being able to acknowledge and accept this is important for the trustworthiness and authenticity of the relationship.

Comment #3

An even-handed critique – and as you intimate, little is gained by "blaming" the other. Further, I do not see it as an exactly "equal" relationship. Although of course patients should not bad-mouth physicians, it violates the physician's code of ethics to malign their patients. Physicians must learn to empathize with their patients' shortcomings while helping them improve; and they must learn to turn a critical (but not shaming) eye on their own less-than-stellar behavior.

Comment #4

I'm not quite clear of your point here. I think excessive wait-times are a significant source of discussion, and should be addressed both individually and systemically. For the person who has taken time off work, hired someone to watch her kids, or left her elderly parent unattended, it is not "something small."

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Comment #1

This does sound awfully demanding and inappropriate. Why do you suppose the patient was making these demands? What was he expressing when he threw his food on the floor?

Comment #2

Brilliant, Cyrus. This is a very insightful observation on your part. I suspect that much of his behavior, both regarding the hospital food and the resistance about the SNFs emanated from his feeling scared and out of control.

Comment #3

Good for you for not "responding in kind" and continuing to be professional and direct. I'm curious in what ways you were "direct," but in any case it appears the patient appreciated your forthrightness.

Comment #4

This is exactly the right lesson. It is natural to feel frustrated and irritated by a patient who is slinging his food about. However, we can also feel interested and curious: Why is he behaving in this manner? What is he trying to tell us? What does he hope to get out of this behavior? Thinking about

such issue often reduces frustration, and encourages us to figure out what's going on with the patient (just as you did!), gleaning insights that will enable us to better care for the patient.

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Comment #1

We have preconceived notions about what makes for a "difficult" pt/dr encounter. You point out that the physician's countertransference can bring its own challenges. Yet, as your attending demonstrated so well, appropriate countertransference can help connect doctor and patient.

Comment #2

This was truly a brilliant insight, Sean. By making "patients" different from "doctors," we create a safe distance between the two groups. Patients are one type of people (to whom bad things happen) and doctors are another type of people (who fix the bad things that happen to others). This is a prevalent form of thinking in medicine, but of course the truth is more complicated. As you go on to observe, there are both differences AND similarities between doctors and patients, just as there are between all people. Keeping that in mind, as you perceptively conclude, is precisely what will make you a good doctor who truly serves his patients.

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Comment #1

You reached such a different conclusion than the more typical one – "This patient just doesn't care about her health." In fact, you realized that she cares a great deal, but has not been able to figure out how to translate this aspiration into reality.

Comment #2

Great job of discovering what really motivated this woman – not so much self-care as understanding her health as an extension of her caring for/commitment to her family.

Comment #3

Oh, this is really sweet, and shows how well you connected with her! As we discussed today, you have succeeded in establishing a therapeutic relationship with your patient when the patient feels you CARE about her.

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Comment #1

Nice work, Brenton. This is the “evidence” that indeed you did develop a good relationship with your patient, as patients normally do not disclose readily about feelings of depression unless this is the focus of the interview, especially with a physician they’ve just met.

Comment #2

This is one of those cases when a “simple,” “sameday” encounter becomes a surprise, and you have to adjust your approach accordingly.

Comment #3

I’m not sure I entirely agree with your assessment. As above, it is quite possible the patient’s depression would never have become evident without your ability to establish a connection. I also suspect that it was your presentation to the resident that helped him focus his education of the patient to provide maximum reassurance and hope.

Comment #4

Again, I can only partially concur. The resident’s explanation sounds outstanding. But I wonder whether it wasn’t your taking time to listen to and understand the patient that made her feel cared about and heard. This created fertile ground for planting the explanatory seeds. One without the other, in my view, would not nearly have been so effective (just my opinion ☺).

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Comment #1

Good awareness of this phenomenon, which is common in medicine, and obviously occurs in other clinical situations as well.

Comment #2

Interesting that she felt you would be more empathic to her perspective, even though you did not share the same cultural background.

Comment #3

I can see you were paying attention on psychiatry! ☺ Splitting is a common manipulative strategy (all of us are capable of it) that undermines teams and pits people against each other.

Comment #4

Excellent that you were able to determine whether, as the patient believed, cultural factors were influencing the diagnosis; or whether she did exhibit bizarre ideation independent of culture.

Comment #5

I wonder what were the circumstances under which these tapes were made. By the patient? In a clinical setting? For what purpose?

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Comment #1

I think it is very brave of you to admit this. It would be nice if you could solve what sounds to be a 25 year problem in one 10 minute interaction, but this is probably holding the bar pretty high ☺.

Comment #2

this is an interesting observation. The relationship between physicians' own self-care (or lack thereof) and the counsel they provide their patients is a complex one. Sharing a problem with a patient can make the physician more empathetic; OR it can make them feel helpless or frustrated or even angry (often projected feelings that have to do with their frustration with their own situation) The key is to use what you know from your own or family members' or other patients' struggles to dig in for the long haul with the patient (of course, not realistic for a medical student, but the right approach for a primary care physician), recognize the many competing problems and stressors, don't take setbacks personally, help co-create innovative approaches with the patient, stay calm and carry on ☺

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Comment #1

Thank you for honestly recognizing this reaction in yourself. All of us can easily fall into judgmental attitudes, but these are rarely helpful in advancing patient care. Awareness of our own biases and frustrations can help us get a handle on them so they do not interfere with patient interactions.

Comment #2

Oh, this is so unfortunate. Time constraints often compromise the care we are able to provide patients. In this case, you were just at the point of evolving beyond your (understandable) initial impressions to a deeper connection with the patient when you were pulled out.

Comment #3

We cannot know the attending's perspective, or what knowledge he held about the patient, but it is probably safe to predict that the prescription refill and the glucometer in and of themselves will do little to help this patient.

Comment #4

This way oversimplifies your dilemma, but taking time to listen to the patient's perception of her situation can often save time in the long run as well as provide ideas about how to really HELP the patient.

Comment #5

Again, I don't mean to second-guess your attending, and the point of this reflection exercise is not ti criticize specific situations where certainly I and even you may not have all the information. That being said, I would also like to suggest that "time does not permit" can be both reality and an abrogation of the physician's responsibility to the patient. If time after time, there IS no time to get to the bottom of the patient's problem, then the patient is not being well served. Similarly, while the physician (or medical student) "keeping afloat" is in everyone's interests, including the patient's, it cannot be the overriding priority. "Picking your fights" is good advice, certainly, but it means that you SHOULD pick some fights, and not simply avoid the challenging situations. I hope by this point in the year you have observed many attending who both know how to "keep afloat" and to find time to offer real help, as opposed to the appearance of help ("more stuff") to the patient.

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Comment #1

I hear what you're saying about cultural differences being an additional barrier in communicating effectively with this patient, and I agree with you. However, as I'm sure you discovered on Peds, parents from many different backgrounds have become convinced that vaccinations are harmful to their kids. Indeed, it is an extremely frustrating and frightening issue when we look toward the future.

Comment #2

I think many pediatricians and family docs feel exactly the feelings you do. However, the best hope of persuading parents toward immunization is by taking the time to understand their concerns. When the parents are very firmly set against vaccination, even presenting evidence as to the safety of vaccinations may not sway them. But some parents occupy a middle ground, and by treating their worries with respect and patience, they can sometimes be moved toward immunization. This approach is probably the most likely to succeed regardless of the parents' cultural background.

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Comment #1

The patient's life seems quite overwhelming. How can you conduct the interview without giving him the message that you don't care about his very difficult problems?

Comment #2

I appreciate your sensitivity to how the interruption might have negatively affected the interview. A common mistake many of us often make is to wait and wait until way too much time has been lost, then try to regain control by "interrupting," usually perceived as a somewhat rude or thoughtless act.

Comment #3

Of course, you were not feeling that this was "great" at all. You were probably frustrated and had used up your patience a long time ago.

Comment #4

I really appreciate your honesty. We all "lose it" occasionally, and cannot always be the perfect people we expect to be. By thinking about the (pretty challenging) circumstances that made it possible for your frustrations to drive the end of this encounter, you may develop some insights that will help you manage similar situations in the future in a way that is more satisfying for you and for the patient.

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Comment #1

This is a natural reaction. When we feel frustrated and helpless, we look around for someone to blame. Sometimes we blame ourselves, sometimes we blame the patient, sometimes we blame both! In my view, frustration can be a valuable emotion if it spurs us to action – i.e., taking a Spanish class; but less useful if it influences us to be irritated or judgmental toward the patient.

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Comment #1

From the physician's point of view, these additional lesions had already been dealt with and the attention needed to be focused on the possibly cancerous lesion on the forehead. From the patient's point of view, her world has been upended by the possibility of malignancy, and she is having trouble trusting anything. Her behavior, while distracting, does make sense from this perspective.

Comment #2

Daughter thinks she is trying to help her mother. It is natural for patients and their family members to wonder if a specialist wouldn't know more/do a better job than a "generalist."

Comment #3

I agree, the physician handled this challenge to her competence well. However, it is also possible to see such a comment not as an attack but as an opportunity. Ask yourself, what is really going on here? Why have patient and daughter suddenly lost confidence in their doctor? At least in part, it is likely because they feel scared – they are suddenly in completely unknown territory, and the only person to guide them is someone they barely know.

In these circumstances, it also would make sense to acknowledge the daughter's anxiety, and to reassure her that if this were something outside her expertise, the doctor would be the first to suggest a referral. Then she could go on to say, as she did, that if the patient and family preferred, she could still make the referral. The main point is not to be defensive, and to acknowledge how scary this situation is.

Comment #4

Of course, it is natural for a physician to be offended when a patient questions their competence. It's important to remember, however, that many patients have no idea what different specialists are trained to do; and their questioning is likely to reflect their own anxiety more than actual doubt in the skills of the doctor.

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Comment #1

This essay is very effective in highlighting both the vast differences and overlapping similarities between you and this patient. I wonder whether you ever thought at some point, "There but for the grace of God [or fate or the universe}…"

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Comment #1

Excellent, this was already one hurdle which you overcame. There is an interesting study that shows when people view pictures of fat, normal weight, and skinny babies, the majority prefer the fat babies. So it can be surprisingly hard, for a variety of reasons, to recognize that your very own precious child is overweight.

Comment #2

Of course, this is a problem in itself. But as we discussed, sometimes lifestyle/dietary interventions that target the entire family are more successful than singling out a single individual. Perhaps working on weight loss in enjoyable, creative ways could even become an alternative source of bonding for dad and daughter.

Comment #3

Excellent awareness of all the reasons why this is going to be challenging, and not accomplished in a single encounter. Weight loss is a commitment to a process, on the part of both patient and physician, and involves plenty of steps backwards as well as forward. Still, intervening with a child, as in this case, gives you a good chance of real success.

Comment #4

Yes, to me this is the biggest culprit. Fast food is convenient and cheap. Calculations differ – but it can be less expensive than healthier foods if fruits and vegetables are not easily accessible.

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Comment #1

I think the tricky thing with this aspect of patient autonomy is you want to be extremely certain that the pt truly does understand the risks in not following medical advice. In other words, is it an informed, thoughtful choice?

Comment #2

Wonderful – when you see some aspect of the clinical encounter not working, start asking yourself why? What is going on here? Depression is one possibility. As you go on to consider, there might be others.

Comment #3

This is not the last time you will have this feeling. ItThe important thing is to have the courage to reflect on your encounters and ask yourself, what did I do right? What do I want to make sure I keep on doing? Where did I fall short? How can I do a bit better next time? Don't be too hard on yourself, but have the courage to learn from each interaction.

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Comment #1

It's always good to have your plan carefully prepared. It's also good to find out what the patient's "plan" for herself might be – how aggressively does she want to be treated etc.?

Comment #2

It might be less about minimum vs. maximum, although there is a truth in this, but also factoring in quality of life, which it sounds as though your resident was doing.

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Comment #1

Very good self-awareness – the eager physician-scientist in you longs for those fascinating

diagnostic puzzles. Yum yum ☺

Comment #2

And if I may add, you weren't only part of a wonderful machine, you were part of a man's life. And you had the wonderful model of seeing that "machine" function well to respect and honor that life, even at its end. Nice work, all of you.

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Comment #1

Yes, it sounds as though it must have been very difficult to clearly convey what happened when so many people were involved.

Comment #2

Although no one did anything wrong, the fact that there was such a tragic outcome can be very hard to accept. This is the logic, but by holding someone accountable, it makes it seem as though all of this could have been avoided.

Comment #3

You've got it exactly right. This can be very hard to do when people are threatening lawsuit, but in the end patience and understanding will help the family accept a truly terrible situation and focus on how they can best support the mother during this ordeal.I'd be curious to learn how you managed your own emotions as you and the team navigated the various dynamics.

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Comment #1

Perhaps we can talk more in class about how to handle a situation when the patient refuses to consider a medication, but also does not want to explain the reasons.

Comment #2'

Very good insight – sharing a language can be a great help in discussing sensitive and difficult topics. Also, it is possible that she knew the resident and had more of a relationship developed with him.

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Comment #1

This is such a hard conversation to have in the ED with a patient you've just met, in a second language. I admire that you attempted it. I'd be interested to hear how the patient reacted and how you thought it went.

Comment #2

In my view, you did all you could. You received his story, you gave him your time and presence, and you tried to help him understand his situation. You were up against large societal forces involving

healthcare in this country which you cannot control. There is many things to lament in this situation, but your behavior is not one of them.

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Comment #1

We can use the technical term of countertransference, but the important thing to note is that this kind of identification with patients occurs all the time and can work to the good or the ill of patient care.

Comment #2

True, he is not your brother. But I wonder what this professional distance is? How big is it, for example? And why is it there? To protect the patient? To protect the doctor? What does this term really mean and why do we seek it?

Comment #3

Sometimes hugging a patient is the best thing you can do for them – however, as you probably know, it depends on your reading the patient's needs, rather than your needs, well.

Comment #4

So not only the patient is feeling helpless and despairing, but his doctor is feeling similarly too. This can be a scary situation for everyone, and can lead to less than optimal outcomes. I wonder how they might be mitigated.

Comment #5

I wonder if color "blindness" is exactly the goal you seek, as awareness of patients' cultures and background can help us understand them and their stories. Perhaps what you are really saying is that racial/cultural differences are not always the most important thing, and that the commonalities of suffering can easily trump such differences.

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Comment #1

Excellent realization that there is indeed a power imbalance in medicine; that power flows unequally between doctors and patients; and that this is especially pronounced when class differences are implicated.

Comment #2

Haha. This likely describes much of the third year experience. I admire that you were able to be in touch with the discrepancy between the outer Stephanie and the inner one.

Comment #3

Good awareness of your own emotions – when we feel overwhelmed, sometimes there is a tendency to blame the person who "made" us feel this way. So there is the possibility of blaming the patient, although all the patient has done is share himself and his situation. Awareness of your own emotions is the first step in ensuring that such emotions do not negatively influence patient care.

Comment #4

This was fantastic, Stephanie. You did not fall into the trap of feeling only pity for your patient. Despite his many challenges, you were able to see him as a three-dimensional person with many strengths, such as prayer and a sustaining life philosophy.

Comment #5

In my view, you've found a great balance. You are able to see how difficult it is for you to really comprehend this patient's life experience – his level of helplessness and powerlessness, which is so different than yours as a (relatively) privileged person. Yet you do not deny, indeed you embrace your common humanity.

Comment #6

Another wonderful statement. You have allowed this patient to affect you, maybe even to change you a little bit. You have allowed yourself to care about him, to root for him. I think this is an important part of what all patients hope to receive from their doctors.

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Comment #1

Don't estimate the value of nonverbal communication. Research suggests that patients pay more attention to their doctors nonverbal communication than their actual words.

Comment #2

This is an excellent point. There are specific skills in working with an interpreter (looking directly at the patient, speaking in shorter sentences, ensuring that the interpreter will translate EVERYTHING you say, and when appropriate using the interpreter as a cultural broker) and developing these skills can really improve the quality of the interaction. Making a personal connection with the interpreter (as well as the patient) also helps.

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Comment #1

I would be very interested in HOW you did this. In other words, what language did you use to encourage the daughter to back off and give the mom some space? How we phrase these things conveys a lot to patient and family member, and can complicate or improve the interaction.

Comment #2

This is an excellent insight, Garen. Doctors sometimes think, "This encounter would be so much easier without this family member." Perhaps. But diseases are attached to patients, and patients are attached to families, and families have a profound impact on how patients respond to their diseases. So you're right, it is not always smooth, but if you are able to "enlist" the family to help further the goals of patient health and wellbeing, you'll achieve much more than by pretending the patient is an isolated individual without any social context.

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Comment #1

A great attempt to "retool" the standard interview – take a different approach to find out what you need. Very flexible and creative.

Comment #2

Many Christian Scientists do not seek medical attention; or only in very serious situations. It's interesting that she is attempting to balance both.

Comment #3

I wonder if, in a continuity care relationship there might be room for negotiation here. It seems to me it does place the patient at a disadvantage to not have any knowledge about how medicine views her symptoms. Perhaps over time she would be willing to learn more "as one way of understanding". It would still be up to her as to how to respond (medication, prayer, a combination of both).

Comment #4

I'm impressed. Rather than be judgmental toward the patient, you educated yourself about her beliefs. If you were actually going to be her doctor, this would be absolutely the first step to take.

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Comment #1

Excellent – although it is challenging to communicate across language, you can pick up a lot by paying attention to nonverbal and body language as you did.

Comment #2

And what a good attitude – to enjoy the challenges (which are real) of the experience, rather than be frustrated.

---

Comment #1

Good call. Your goal initially is not to point out the holes in your patient's schizophrenic logic but to show him you understand his beliefs.

Comment #2

Psychiatrists often say that collateral information is both extremely difficult and time-consuming to gather and extremely important in understanding the patient.

Comment #3

Pragmatic and relevant conclusion – as long as your patient is alive and getting help, you will always have a chance to further refine the formal diagnosis.

Comment #4

Great attitude! If you can see "difficult" patients as an opportunity for learning, you will be interested in them rather than resentful of them.

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Comment #1

Patient is always a good place to start in situations of noncompliance, but often you will have to be prepared to tackle the problem in other ways as well.

Comment #2

And, in my view, this was exactly the best possible use of your time. The psychological stress was clearly an underlying problem that severely affected the patient's ability and desire to comply with medical regimen.

Comment #3

I agree completely. In a certainly challenging situation, you managed to get to the root of the problem, and might actually have made a real difference in this patient's life.

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Comment #1

Yes, you state very well how lack of fluency/true bilingualism can hamper an interview. Even individuals who have a basic grasp of another language can miss the nuances you describe. It must be especially frustrating to catch them, but not have sufficient language to precisely respond to them!

Comment #2

This was an excellent idea on your part. Since you knew what you wanted to say, but could not find the words in Spanish, you used nonverbal language to convey your emotions.

Comment #3

I completely agree. As well, in these circumstances, you might consider sharing with the patient that , because of your own language limitations you can't always express yourself as fully as you'd like, but that you do understand her very well and feel for her situation. That way, you've owned the shortcoming as your own, and the patient doesn't have to make inferences from your apparent inarticulateness.

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Comment #1

That is a very open self-assessment. A great skill in a physician is to be able to look honestly at oneself and learn from one's mistakes – which we all make, often!

Comment #2

Completely well-said. The arguments that you might find compelling will not necessarily be persuasive to your patients. Cocaine use is never a "logical choice," therefore logic can rarely undo it.

Comment #3

Exactly. Same with smoking, drinking, sedentary lifestyle, poor diet. Unfortunately, usually these choices are not the result of lack of knowledge.

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Comment #1

It sounds as though this patient had many reservations and concerns about the flex sig procedure. Was she afraid? Confused? Lacking trust in her doctors? Possibly personality disorder? Until these questions are answered, it might be premature to proceed with the flex sig.

Comment #2

This is a very difficult situation. The patient's story keeps shifting, so you are no longer sure you are working from accurate information. Did she have prior imaging? Was the scheduled procedure actually contraindicated?

Comment #3

If this were the case, you would want to be especially careful that she in fact had given informed consent to the proposed procedure.

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Comment #1

It is certainly true that society tends to prioritize patient autonomy, sometimes inappropriately. It seems to me, however, that it is just the tip of the iceberg to say that this patient is exercising autonomy. Why is he choosing to do harm to himself? What makes him miss appointments? Is it simply lack of caring?

Comment #2

You know, from an ethical perspective, my question would be the following: This outcome probably benefitted the physician, since how he or she did not have to spend time on this noncompliant paper. But how did this outcome benefit the patient? Maybe being "fired" would be a wake-up call. Or maybe the same futile patterns just kept repeating.

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Comment #1

Well I wouldn't describe the student as a "fake," but especially where their children are concerned, parents want to do everything in their power to ensure the best care.

Comment #2

Your analysis is a good one – this mom is terrified for her daughter; and sometimes people express fear through anger and threats.

Comment #3

Good for you for trying. This is a good example of how, although most healthcare professionals recite the mantra of cultural sensitivity, in practice it is often ignored because it requires more work and people to change what they consider appropriate behavior.

Comment #4

I think when you find something to admire even in the most difficult family member or patient, you have already established the beginning of a constructive relationship on which you can build to promote the patient's wellbeing.

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Comment #1

I wonder why she "does not want" to address her medical issues. Do they have a different meaning for her than for her doctors? Is she afraid? Is there a financial burden? Are these problems simply not a priority for her?

Comment #2

So this is an interesting discrepancy. Is she lying about her medication use? Does she believe she is compliant? Is she afraid the physician will judge her if she "confesses" her noncompliance?

Comment #3

Are you completely convinced that this is the main problem? – i.e., that she “doesn’t care enough” about her medical problems? Are there any other possible explanations? What does it mean when we say, “she doesn’t care about her disease?”

Comment #4

This may be an interesting clue to the patient’s perspective. If she “feels fine,” then perhaps it is easy to conclude that “there is no problem.” Is it possible this might be a starting point to revisit the issue of noncompliance?

Comment #5

Excellent observation! I wonder if it might be possible to bring this behavior to the patient’s attention, and ask her to help you understand better what it means. Is she trying to “wiggle out” of a serious conversation through jokes and giggles? Are these signs of discomfort with a distressing topic she wishes to avoid? What might you try to help her take this conversation more seriously.

Comment #6

So Dr. Nguyen chose not to “collude” with her giggles, but rather emphasized the severity of this problem. Do you think that was convincing to the patient? Do you have hope that she will tackle her smoking once she leaves the exam room?

Comment #7

Very wise. Patients can feel overwhelmed by the enormity of the multiple health problems confronting them. Focusing on the “low-hanging fruit” (although smoking rarely is such) can give the patient a feeling of success and hope.

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Comment #1

This was a great suggestion. What was the thinking behind it? If the brother/healer had been able to come, what would your goals have been in interacting with him?

Comment #2

you cannot guarantee the outcome in medicine, no matter how sincerely you try. I don’t think that means your efforts are “wasted.” Making your best possible effort in every situation is what is required of you as a physician, even when the outcome is not positive. In this case, how wonderful that you met with success!

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Comment #1

This is so interesting. It's actually the first time I've heard of our national political debate entering the exam room! She's actually making some good points, but at least in my view, they don't have anything to do with the Affordable Health Care Act. In fact, these concerns about the doctor-patient relationship go back decades.

Comment #2

Yes, good awareness. The encounter has suddenly swerved off its predictable tracks. It has become contentious and… political! Who knew? I wonder after this unexpected twist what you think was the reason your patient started the encounter with this declaration> What might she have been worried about? Understanding your patient better might help you develop some new goals for the encounter.

Comment #3

Yes, it is always hard when we feel we're being attacked personally, especially when all we've done is walk through the door trying to be helpful! Since she didn't know you, it actually wasn't especially personal, you were just a convenient target, but it FELT that way. Unfortunately, this happens in medicine on occasion, because patients are often in vulnerable situations where they feel frightened, helpless, dependent. We can hear that in your patient. So the challenge is to learn not to take the attack personally, instead hear the fear beneath the anger, and figure out how to reach out to this patient despite her hostility.

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Comment #1

Good awareness, Ilya. It is one thing to be able to take an ob history in Spanish, quite another to ask about intimate and vulnerable emotions.

Comment #2

This is disappointing. However, there might be some consolation in knowing that even an experienced clinician fluent in Spanish struggled with this patient. Sometimes, despite their best efforts, physicians struggle with patients. In primary care, they return to struggle another day, and if they're respectfully persistent, sometimes they succeed.

Comment #3

This is certainly quite possible. He may have been distrustful, yet part of him trusted enough to show up in clinic. He may have felt ashamed of his depression symptoms. He may have been unable to

express himself in words. There might be many reasons for his inarticulateness, and part of the job of a good family doc is to find out what they are.

Comment #4

It is hard to know what to do in such a situation. One option – which might or might not help – is to make the problem explicit. In other words, to say in effect, “You seem uncomfortable talking with me. I would like to ask a few more questions so that I can take good care of you, but what can I do to put you at ease?”.

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Comment #1

To me this sounds like a rather unproductive pattern: physician offers vaccine, patient refuses. How else might you approach this issue?

Comment #2

Indeed, this is a very frustrating situation. You and your patient are not working as a team. For some reason, NT is suspicious of all (or most) of the recommendations you made. The important thing is to find out why? What is her thinking? For some reason NT also keeps coming to seek medical care? Why is that? How does she hope medical care will benefit her? There is a disconnect here that deserves further examination.

Comment #3

Yes, it is a right, but only when the patient is making a truly informed decision. What I worry about in this and similar situations is that the patient is making choices out of fear or mistrust. Probing the patient’s thinking and feelings is the only way to move things forward.

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Comment #1

This sounds very aggravating, especially in that the patient triggered the cycle himself by not complying with the diuretics.

Comment #2

I suspect it was not ONLY a lack of education and a lack of understanding, but perhaps also a lack of anyone showing an interest in or caring about him that factored in to his truculent behavior.

Comment #3

How wonderful you took the time to discover that there might be a fairly simple solution to an apparently personality-based problem.

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Comment #1

Unfortunately, given the pressures toward productivity and efficiency, this happens more often than we'd like

Comment #2

This is a good sign that it is probably not a good idea to proceed with "business as usual." The pt's agitation has become the chief complaint!

Comment #3

Yes, there are certainly situations in which you must prioritize your own safety; or in which it is necessary to give the patient space to calm down.

Comment #4

How can you be so sure? Perhaps a calm and reassuring demeanor prevented the situation from becoming even worse. Perhaps the pt's attitude shifted because you had not abandoned and she had begun to trust you.

Comment #5

Indeed, this sounds like an extremely difficult interview. You were dealing with a mentally ill pt, a distraught mom, and only your limited clinical experience to see you through. I think you did an excellent job.

Comment #6

What a wonderful lesson you drew, albeit at some cost to your own wellbeing. You know the famous Osler quote - "It is much more important to know what sort of patient has a disease than what sort of disease a patient has." This encounter perfectly embodies that insight.

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Comment #1

Right here, you show great awareness, James. Rather than seeing “noncompliance” as the end of the story (this patient doesn’t care about her health), you want to learn more, you take her noncompliance as a starting point. Excellent!

Comment #2

Yes, we always have our own ideas about why people behave the way they do. Of course, this isn’t wrong – in fact, it’s thinking actively about your patient, which is good – but as you did so skillfully, you always want to check out your theories with the ultimate authority – the patient. In this case, doing so taught you something that you never would have suspected!

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Comment #1

So the patient is in denial, despite repeated interventions from family and health care professionals. A very frustrating situation. Can anything further be done to address this issue?

Comment #2

What kind of stories did he tell? Did he tell stories as a method of deflection? Were these happier memories that he preferred to dwell on?

Comment #3

These stories sound like they are about things that interest the patient a lot more than his neuropathy and other medical problems.

Comment #4

Wow! This is such a great insight, James! You are really on the right track here. So far (i.e., in one encounter) you were not successful in transforming this patient, who has probably been alcohol-addicted for decades. You couldn’t even get him to acknowledge that you saw more clearly what was going on with the patient than he could see about himself! This is all very ego-deflating. I am so impressed that you’ve gotten to this level.

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Comment #1

This is an excellent analysis of all the many points at which communication could go astray in this particular case. And the more people involved, the more chance for error (add the resident, the

attending; in a hospital setting, other specialists and consults). Even without language differences, communication is a lot more complicated than we sometimes think!

Comment #2

Excellent points. Even when the problem is a simple one, communication can easily go awry. When the stakes are higher, clear communication can be even harder to achieve.

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Comment #1

Excellent observation of your patient. Even in the absence of a shared language, you can learn a lot about the patient by paying attention to nonverbal information and cues.

Comment #2

Excellent. You are thinking proactively about the patient (as is your preceptor) trying to put the pieces together in a way that makes sense.

Comment #3

I believe this is true. It can also be true that, when people are uprooted from their homes, language, and culture, struggling to function in a strange society, these historical patterns can be harder to preserve.

Comment #4

And of course, this is a sensitive qualification. We are always better off holding general knowledge that relates to groups and cultures, but not making specific assumptions about specific individuals.

Comment #5

I love the humility in this statement, James. Most times we DON'T understand someone else's situation completely, and it is very tempting to make snap judgments based on very limited information.

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Comment #1

Dry thumbs is a new one to me (dry skin maybe, but thumbs only?!) At this point you are probably thinking that your patient has multiple social conditions, as well as perhaps contributing psychiatric

issues. She herself may be aware of cognitive changes or decline as she mentions dementia on her "problem list."

Comment #2

She is certainly "testing" both you and the attending. The tricky part is to determine whether this is a conscious personality choice or again attributable in part to possible psychiatric issues.

Comment #3

Janis, you are asking exactly the same questions I would be asking; and you are correct that it is hard to make a determination when you have no baseline.

Comment #4

An interesting comment. While a certain amount of mild, occasional "forgetfulness" may be within normal limits, you want to be careful to avoid attributing symptoms of diseases processes to old age.

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Comment #1

Yes, you clearly had run into a strong cultural construction of the marital relationship, in which the husband is the dominant one, the decisionmaker; and each has a defined sphere of influence. Such rigid and unequal roles can be very frustrating for an American, but it is usually not practical or possible to disrupt them.

Comment #2

I would have found this upsetting, but I still feel these patterns cannot be changed in the healthcare setting, only worked within. Since the husband was calling the shots, I wonder if it was possible to talk to him about his wife's suffering, especially since he seemed genuinely concerned. Maybe there was a way to use their traditional dynamics to help him better understand her level of distress.

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Comment #1

Good for you. This is what having an open mind means. Not that you will necessarily end up agreeing with your patient, but that you are willing to take his perspective seriously.

Comment #2

I have a lot of respect for your shift in attitudes. Having a more open and nonjudgmental to the views of your patient ultimately will enable you to better care for your patient.

I do find it interesting that, when the patient had chest pain, he went to an ER rather than rely on a traditional remedy. This suggests to me that part of him might be open to certain types of Western medicines. If he were actually your patient, this might be worth exploring to see if you could not identify an approach that integrated the best of east and west.

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Comment #1

It can be very, very difficult for people to admit that they cannot control themselves and their lives sufficiently to avoid lifelong medication. This might be especially true if you have familial and personal beliefs in the efficacy of natural approaches.

Comment #2

I agree with you. You are probably giving him time to get used to the idea of medications; rather than time to revolutionize his lifestyle. But patients will only comply with medical advice when they are ready. This patient has already shown he is really struggling with the idea of long-term meds. What you've done is open a dialogue.

Comment #3

Yes, this is the risk you are taking. In fact, that would be a topic to introduce during the encounter. Share your fears and let him respond. To reduce the likelihood of this outcome, it's important to convey both nonjudgmentalness and caring to the patient, to use every tool at your disposal to ensure his return to clinic.

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Comment #1

When we probe a little deeper, it is often in fact difficult circumstances that make for difficult interactions. It is easier to blame on an individual person – who we perceive as being able to "change" – than to acknowledge the powerful societal forces that result in so much injustice for so

many. “Hopeless” is a very understandable reaction to such overwhelming issues. Hopefully, it can be a starting point.

Comment #2

I admire how hard you were trying to help this patient. Every day I see individual physicians making heroic efforts to do the right thing by their patients, whereas in a country with universal health care none of this would be necessary.

Comment #3

I suspect one of the things that makes this so hard is that you, as a medical student become complicit in the failure to adequately care for this woman because you (and all of us) are part of the healthcare system that is supposed to treat her. No wonder you felt helpless and hopeless. But not everything can be solved by goodhearted people doing their best. We also need to think what we can do (even in very small ways) to try to change the system. I think there is a place for physicians as agents of social change, as well as individual healers.

---

Comment #1

You’re right that as a third year student and talking about the diagnosis of someone you are hearing about third-hand you don’t want to say anything very specific.

Comment #2

When people ask us questions, we often feel we have to provide an answer, even if this is not appropriate or we have no idea. Sometimes the best thing to do is say honestly, “I don’t know. What do you think?” which is the more important thing in any case.

Comment #3

No wonder you were looking for a way out! The patient placed you in an uncomfortable position, of course only because she was so confused and distressed. You might have done several things. You could have explained that patients usually go to hospice when the emphasis of care is to make the patient comfortable and reduce pain; then if the patient had further questions you could have answered them. You could also have turned the conversation back to the sister, commenting that it sounded as though both she and her sister had a lot of questions and confusions about what was going on with the husband’s care, and that the best person to answer these questions would be his doctor. I would not want to brush her off, but I’d also be worried that the information is so unreliable

– is the diagnosis accurate? Is her impression that he's been discharged to hospice correct? Above all, I would support her concern for her sister, the sister's husband, and herself; and empathize with the extreme stress and difficulty of the situation.

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Comment #1

I agree that some other cultures often hold physicians in high regard, and this positively influences compliance. Of course, other cultural factors can work against compliance - I wonder if you can think of any.

Comment #2

It sounds as though this patient, as a longtime diabetic patients, had her own ideas about her treatment. I wonder how this tendency could have been utilized in developing a treatment plan.

Comment #3

You are correct that the physician might have better anticipated this patient's developing her own "interpreted" treatment plan, and warned her against certain non-indicated actions. However, I still am curious as to whether the physician could have used this patient's desire to play an active role in her own healthcare to develop more of a partnership with her.

Comment #4

Excellent conclusion. The person who has the professional obligation to adapt his/her style to the needs and preferences of the patient is the doctor.

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Comment #1

This is important information, because it reveals the patient's thought process that keeps him from addressing his diabetes. He feels "fine," his body has "adjusted," so no problems. This is what will have to be discussed before any changes can even be broached.

Comment #2

This suggests that there is a part of Mr. L who understands that he is "not fine" and that his body has "not adjusted," and that he still needs medical help. This too is an opening.

Comment #3

Evidence is very compelling for doctors and scientists, but there are a lot of people who are not persuaded by mere evidence. I think he did hear the evidence, which showed he was still sick, but wasn't willing to act on it (except to ask for a different medication). How to close the gap? Maybe he thought an endocrinologist has more expertise? Maybe he thought another doctor would tell him what he wanted to hear?

Comment #4

That is true for sure. It is also important to try to understand the patient's perspective and look for a way to identify common ground. Very hard in a brief encounter, but necessary.

Comment #5

Agree. By making the referral, and not resisting or being defensive about a second opinion, Dr. L conveys to the patient that she is willing to explore any (reasonable) avenue and listen to any (legitimate) perspective that might provide a solution. Very nice!

---

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---

Comment #1

This has become the most important issue in the exam room – not the patient's diabetes. You can address it directly, talk about her discomfort in seeing a student, and why this is important.

Comment #2

Excellent! You're giving the patient a different way of framing your role – rather than just one more person to give something to, you will actually make the visit go better.

Comment #3

It sounds like she's worried about your level of training and competence. You can make this explicit, and then reassure her that you are only allowed to provide information and ask questions appropriate to your level of training. You can also let her know how appreciative you are that she is acting as your "teacher."

Comment #4

Of course you are right. Unfortunately, many of our patients have very little understanding of what a teaching hospital is, so it is easy for them to become bewildered, anxious, or resentful when confronted by a student. Usually a little explanation and some appreciation for their help – as well as showing them, as you did, how your presence can benefit the patient – can smooth things over. And then once in a while, the patient wants to see the "real" doctor ☺ and you have to accede with good grace.

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Comment #1

Here you need to sort out whether the patient primarily wants drugs; or are drugs a means to the end of preserving participation in something that gives the patient meaning (i.e., body-building)?

Comment #2

I'm sure this is medically accurate, but it challenges the patient's explanatory model. Since his model allows him to keep lifting and using supplements, it will be difficult to wean him away from his ideas

regarding his pain. The medical explanation threatens an important organizing principle of the patient's life.

Comment #3

It is possible that the patient hopes that strong enough pain meds will allow him to pursue his weight-lifting. I suspect that it is around this issue that negotiation and compromise will need to occur.

Comment #4

Excellent insight. Depending on the intensity of this co-dependency, this issue may also need to be addressed so that you can productively proceed. I wonder how you might go about working with the enmeshment of mother and son. I even wonder if weight-lifting is a way for your patient to "escape" mom for a time?

Comment #5

Don't sell yourself short. I suspect that if you had an opportunity to continue this conversation, you could have begun to untangle the mother/son relationship; you could have figured out whether he was actively drug-seeking or more trying to preserve a certain weight-lifting oriented lifestyle; and you could have begun to think about approaches that would have incorporated what was most important to the patient. These are complicated issues that couldn't necessarily be resolved in a single visit, but they are definitely amenable to solution with a little more time and insight.

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Comment #1

you tried many different, and well-conceived, strategies. I suspect, as do you, that whatever was making this patient so anxious had less to do with going to the doctor per se and more to do with his psych issues and possibly his relationship with his father.

Comment #2

In my view, this is exactly the right conclusion. Clinical medicine sometimes requires both patience and perseverance. One risk of trying hard to "reach" a patient and put them at ease is that it is easy to become resentful if the patient does not instantly respond. Sometimes the patient just needs a little more time, a little more trust. You might also get more insight by reviewing his records, as your attending intended doing. I think you can feel satisfied that you established a good rapport with the patient and that he was appreciative of your efforts. This is a strong foundation on which to build.

---

Comment #1

Sounds like she was still coming to terms with her loss of function. As you pointed out, she probably has an element of depression.

Comment #2

Yes, all our patients expect this from us, and rightly so. However, it is an art to really be able to sit patiently without distraction, and listen to the patient with your whole person.

It is worth developing, because it will help you pay full attention to the patient's physical and mental state, and that will help you understand their needs.

I am glad to hear that you have good role models to help you develop this skill!

Comment #3

Isn't that an interesting phenomena? Do you think it is because she has been able to forgive him?

---

Comment #1

In addition to her many medical problems, did this patient also have a psych diagnosis? I would not be surprised if, with all she'd gone through, she was clinically depressed.

Comment #2

Excellent conclusion! Do you think that her original physician missed the diagnosis because he was not paying attention, because he was not really listening?

---

Comment #1

This is probably a very good guess. The first injection had worked well for a bit, and had enabled the patient to continue working. How important do you think her job is to this patient? How hard would it be for her to accept that the "simple" solution which had worked so well the first time was no longer an option?

Comment #2

In addition to all the other challenges inherent in this interaction, I wonder whether you were working across language as well?

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Comment #1

I respect this decision. It might also have been possible to discuss this event with the patient – who otherwise might leave the office thinking how “cute” he is! – partly to set limits (this is absolutely unacceptable behavior), but partly to understand what is going on with the patient. Was he upset or anxious? Was he in a playful mood? In other words, what is the meaning of the behavior? Understanding that is important in figuring out how best to address it.

Comment #2

Since this is a patient and not simply a customer, perhaps an important first step is to find out what is going on with him. Why is he saying “weird things”? Why did he behave in this manner? Is he anxious? Upset? Does he feel this is appropriate behavior? How you address this patient action – which is clearly unacceptable – depends on what it means.

Comment #3

And this is the value of relationship. The nurse knew this patient, knew his behavior was out of character, and was willing to wait for more data. I think there might have been other ways to handle the situation within a relational context, but this was certainly one option, and the option preferred by the “victim” of the patient’s behavior.

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Comment #1

This is a great insight – in many cases, the patient is not able to make autonomous decisions for one reason or another (age, mental incapacitation etc.). Even with a fully competent patient, the family often exerts a profound influence on their decision-making and cannot be ignored.

Comment #2

Yes indeed. It was a lot of time to expend, but just think how much time, effort, resources would have been needed if that mom had not given the antibiotics and the patient had to be readmitted. The team did exactly the right thing.

---

Comment #1

Great job! This really is an important question. Although under time pressure, it can feel like opening Pandora's box, you have to remember that whether you ask it or not, the patient has to live in that box!

Comment #2

A good example of mind-body medicine. If you hadn't asked your open-ended question, the patient might be getting sleeping pills or anti-anxiety agents without understanding the root cause.

Comment #3

I understand completely your helplessness and frustration at not being able to make the patient feel better." I must disagree with the way you're looking at this. It is not the role of the physician to solve all the social problems of his or her patients. What you did was listen to the patient's story, "witness" her distress, not judge her and respected her struggle. Of course this is not something you can "solve." You gave her space to reflect on her dilemma, and sort it through, and this in itself is an invaluable gift.

Comment #4

Absolutely. And this is where cultural "competence" and cultural "humility" intersect. You want to be aware that this dynamic is indeed prevalent in first-generation communities and inquire whether it is playing a role in a pt's situation; on the other hand, you never want to assume that EVERY first generation individual is experiencing this, or finds such aspirations problematic. Balance!

---

Comment #1

And this is the fallacy of superficial "cultural sameness." Just because someone is Hispanic doesn't mean they love tortillas – although many do; or just because the patient is Asian doesn't mean they eat a lot of rice. These are issues to keep in mind and inquire about, but not to make assumptions about.

Comment #2

Exactly, just because you share one cultural link – in this case both Vietnamese-American – doesn't guarantee that you will have deep understanding of the pt.

Comment #3

You sound like you had two very culturally sensitive physician role models, and that you learned a lot from them. I wonder specifically how you understood the connection between experiences in re-education camps as well as the immigration experience and current health. Longstanding trauma and potential PTSD for one, and am sure there are many others.

---

Comment #1

Yes, and this can also be a good time to empathize with the pt's (or family member's) perspective. In other words, move from content (how many doctors will you see before THE doctor?) to process "It sounds like it's been frustrating to see so many doctors. That's so understandable."

Comment #2

Ah, the conflicting agendas of doctor and patient. What matters to the doctor is not always what matters to the patient. How can they be reconciled?

Comment #3

Again, very funny. You paint a vivid picture of the chaos in the room, all the while you're trying to get your hx completed!

Comment #4

Ouch. This seems at the least very inappropriate on the part of the mom. Did she slap you? What did she think was happening? Maybe we can clarify this in class.

Comment #5

I'm not entire clear what you mean here, but I think you're saying it's important to understand this demanding relationship, and I certainly agree.

---

Comment #1

This is kind of an ironic shoe on the other foot, as research shows on average doctors interrupt patients after about 21 sec (but of course for "good cause" ☺) This experience can make you more

empathic to the importance of being heard. That said, lack of focus and interruption is not a great communication style. Your patient may have had some psych issues that really complicated the interaction. Nevertheless, it always helps to start with the patient's agenda: "Tell me what you're most worried about, what's most important to you." Sometimes people interrupt because they are worried the other person is not understanding what they are saying. Focus can be a bit in the eye of the beholder. Your focus as a doctor may not make sense to your patient; she may have a different priority. So sometimes focus must be negotiated. As I noted above, from your description I do suspect that this particular patient's challenging communication style could be explained at least in part by axis II, paranaoia, or bipolar diagnoses.

Comment #2

Again, VERY impressed at your awareness of your own emotions. First step in making sure the physician's emotions do not unintentionally hijack the interaction is to be aware of what they are!

Comment #3

Another good thought – you always have the option to "take a break." Leaving BEFORE you yourself becoming angry or fearful can allow everybody to settle down, without needing to blame or punish the patient for losing control.

Comment #4

Excellent – telling people to calm down rarely works once they've lost calmness. Recognizing their agitation, as Dr. Kwaja suggested, or simply sitting in calm – not hostile – silence as you did, can be much more effective.

Comment #5

I can see you really trying to get a handle on the interview at this point. You know, this might have been a good time to introduce "just sitting together and taking a few breaths." At this point things hadn't escalated out of control, and perhaps the patient could have shifted to a calmer state. And sadly, perhaps not.

Comment #6

At this point, you try to normalize the testing, which is an excellent strategy, but the horse is already out of the barn. Perhaps if you'd stressed this aspect in the initial introduction of the test, the patient

might have been more receptive. However, reading this dialogue, she might still have reacted with hostility.

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Comment #1

I'm so glad you've had such positive experiences. It is wonderful to have the benefit of the many outstanding physician role models who surround our learners.

Comment #2

Mutual respect, recognition of pt autonomy, and acknowledgment of physician expertise indeed go a long way toward creating good dr/pt relationships. Excellent insight. Sometimes in the particular situation, however, translating these abstract concepts into reality can be trickier than we'd like.

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Comment #1

Sounds like you had a great role model in this situation, and because you were paying close attention you learned everything you could from the encounter.

Comment #2

Sounds like you had a great role model in this situation, and because you were paying close attention you learned everything you could from the encounter.

Comment #3

Excellent observation on your part. Medical culture may have one idea about who "should" be involved in a patient's care, or who "needs" to know certain things, but the family may have another. It's not that the family is always right (maybe a sensitive teen would not want the extended family knowing about his self-catheterization), but that the family always deserves respect and understanding – and the awareness that they know the patient better than the doctor.

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Comment #1

Yes, it sounds like a confusing and overwhelming situation. The mother sounds very enmeshed with the daughter, and the daughter perhaps unhealthily dependent on the mother. Yet the mother seems like her daughter's main advocate and support. So it's a mixed bag.

Comment #2

This behavior does suggest drug-seeking. On the other hand, if this has been going on for 20 years, both mother and daughter might know from experience which narcotics do best control her pain.

Comment #3

A good observation. The fragmented nature of her care makes it less likely that any one physician takes responsibility for the patient.

Comment #4

It actually sounds like you did a great deal with her! I wonder though whether you felt satisfied or dissatisfied at the end of the visit.

---

Comment #1

She is a relatively young woman to have so many health problems – there is probably an underlying anxiety that her body is failing her.

Comment #2

Wonderful question! You can take rude behavior personally and defensively – and the patient certainly was rude – or you can become curious as to what is motivating the patient's behavior. Understanding this motivation will help you to better care for the patient.

Comment #4

As proved to be the case here, but not escalating, by listening and trying to understand the patient's point of view, you can often defuse the situation and start true communication with the patient.

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Comment #1

Yes, it is a fine line between sharing important information prior to a patient encounter; and predisposing the student to have a negative attitude toward the patient.

Comment #2

This is an understandable reaction to encountering such chaos, clutter, and filth. I'm impressed, however, that you didn't stop there, but started to imagine the factors, such as physical limitations, inability to pay for help that restricted her ability to care for her home. I wonder too about depression – your description is certainly depressing!

Comment #3

Great question – and with this home visit (as is so often the case when we leave the "doctor's territory" of the clinic or hospital and venture out into the homes of our patients, you see just how complicated "health" can be. It can feel overwhelming, but whether or not we choose to see it, it is the reality for so many of our patients.

Comment #4

One way we can move beyond our individual reactions, which is such an important starting point, is to think whether our personal feelings can lead to social action. Can our sadness and gratitude result in steps, such as volunteering at the student-run clinic or volunteering at a shelter or making a donation to a charity etc. etc., that may change something even in a very small way for people struggling with poverty? Of course this is a very personal decision, and not everyone will reach the same conclusions, but it is certainly worth asking the question.

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Comment #1

This must have been a frustrating and alarming development. Your patient has a possibly life-threatening condition, yet you are unable to persuade him to take appropriate action.

Comment #2

It sounds as though you might have felt that your relative youth and the "diplomatic" approach of the NP contributed to the patient's rejecting your recommendations. Do I understand correctly? I wonder what else you might have done? Were there any other steps that you could have taken?

---

Comment #1

Yes, this is a good point. An individual with paranoid psychosis can also develop cancer or neurological disease, so symptoms never should be “dismissed” simply because of mental illness. But those symptoms do need to be viewed in part through the lens of pre-existing mental illness.

Comment #2

True. The key is to be able to evaluate to what extent the symptoms make sense medically; and to acknowledge that the presentation itself may be distorted because of the presence of mental illness. It’s a challenge!

Comment #3

So the patient rejected the diagnosis of paranoid psychosis and did not feel his symptoms were psychiatric in nature. Unfortunately, this is not an uncommon response in people with mental illness. It takes persistent outreach to enable them to obtain the help they need. Yet often individuals with significant mental illness do not have the continuity support that can provide such ongoing efforts to persuade them in the direction of real help.

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Comment #1

It is very difficult when the physician and medical team cannot help the patient in the way the patient hopes and cannot alleviate his suffering

Comment #2

Perhaps so. But speaking from clinical experience, even low level pain that is intractable can reverberate in interpersonal relationships because, as you note, the patient is irritable and perhaps depressed.

Comment #3

Of course, this is quite possible as well. Excessive alcohol use always complicates a marriage, and as you suggest, other factors may be operating as well.

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Comment #1

Do you think that perhaps a DSM Axis II diagnosis might be involved? Is it possible she was simply in a great deal of chronic pain, which can make people act pretty crazy.

Comment #2

Patients like this commonly evoke initial responses of frustration and annoyance. It is the skillful and compassionate physician who can penetrate beyond this reaction to the patient's suffering (whether subjective or "real").

Comment #3

Good for you. An important starting point is to recognize that suffering is suffering. THEN you can differentiate what kind of "treatment" (whether meds or therapy or some combination) is called for.

Comment #4

Of course you are right about this. I wonder why she fought so hard. From what you describe, she does not sound as though she was drug-seeking. I'm curious about her resistance to help.

Comment #5

This is an excellent insight. With a continuity patient, this would be a wonderful conversation to have – "Help me understand what holds you back from getting help. Let's talk about the kind of help you're willing to receive."

Comment #6

This is an absolutely wonderful insight, Kelsey. There will be A LOT of patients you wouldn't want as best friends – but that's not the point. Clinical medicine is about softening negative reactions to patients (after you've learned from them), so you can build a working relationship that is respectful and patient. You've already figured this out – very impressive!

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Comment #1

Great insight! I suspect that going to the doctor is a reminder of her complex and fragile medical status, which she may otherwise be able to deny more easily.

Comment #2

Yes, a shift needs to occur, although I'd caution that breaking through denial is a tricky process. The underlying fear and hopelessness must be addressed. This is not simply a matter of "educating" the patient about the seriousness of her condition. She has a very good reason for not wanting to see how "serious things really are."

Comment #3

I wonder if you had an opportunity to talk with the husband, who appears to be the primary caretaker. My suspicion is that both patient and spouse are completely overwhelmed. Perhaps other resources could be mobilized to support them.

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Comment #1

Indeed, medicine can be delivered across language and culture, but it is often intangible but essential qualities of caring and empathy that become lost. Good for you to recognizing this and trying to maintain the human connection.

Comment #2

Another great insight. It is not so much our words as the tone in which we express them, and what we convey nonverbally that affects the patient.

Comment #3

Another practitioner might have responded with anger or disgust. But as you analyze it, the patient's choice does make sense from his perspective. This is usually the case when patients make choices that are inexplicable to their healthcare providers.

Comment #4

Yes, very true. Sometimes doctors act as though their advice is "the truth and the way," when in fact it is only the best available, but fallible and limited knowledge that they have to offer. It can be helpful and good counsel, but it should always be situated within the patient's belief system. It's wonderful that you see this so early in your career.

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Comment #1

Excellent. It is very common (and understandable) for patients to maintain eye contact with and direct their communication toward the interpreter. However, as you discovered, by continuing to engage the patient directly through both nonverbal and verbal strategies, you can forge a bond.

Comment #2

Interesting comment. It shows how afraid she is of cancer. I wonder how you responded; or how you might respond to this statement. How could you use this disclosure to both move emotionally closer to the patient (empathy) while at the same time gently challenging her view that ignorance is best? For example, as her physician, you might think it important to know the type of cancer to which the sister succumbed.

Comment #3

This also is a common occurrence, where treatment in Mexico may be regarded as suspect in this country.

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Comment #1

Of course, if you have evidence that elder abuse may be occurring, as a mandated reporter your attending will be required by law to report it.

Comment #2

I agree. Despite the language and cultural barriers, you were able to win her trust and create a sense of safety such that she was willing to disclose her precarious situation to you. Nice work!

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Comment #1

How else could this situation have been handled? How well did the resident explain the concept of PTSD? Did this diagnosis make sense to the patient? How did the patient seem to respond to the idea of “therapy,” which is often viewed as stigmatizing? The resident is probably correct that a sleep aid is not going to solve this young man’s problems, but how the alternative is presented is very important.

Comment #2

This reflects the wisdom of greater experience – it shows the patient the doctor is willing to help him with his problem as he perceives it, but also helps him see he has a deeper problem.

Comment #3

As per above, rest alone may not positively predispose the patient to therapy. How many 19 yr olds think they need psychological counseling, especially those from a tough environment? I think this whole idea has to be presented very carefully – maybe using an analogy to soldiers and war.

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Comment #1

I sometimes wonder what we mean when we say the patient is “in denial”. Does this mean he does not accept he has diabetes? Does it mean he knows his diagnosis but “feels fine”? I wonder what is causing him to “disengage” from his illness; what is underlying his noncompliance?

Comment #2

I sometimes wonder what we mean when we say the patient is “in denial”. Does this mean he does not accept he has diabetes? Does it mean he knows his diagnosis but “feels fine”? I wonder what is causing him to “disengage” from his illness; what is underlying his noncompliance?

Comment #3

Again, I wonder to what extent this is a problem of insufficient education. Does the patient lack information? Does the patient lack for facts about his disease? Are there other factors that might be influencing this noncompliance or apparent disinterest in his illness?

Comment #4

I am sure this was true, and yet it may not adequately encompass the full story. Noncompliance is often a complex phenomenon that may be rooted in education/knowledge, but also in socioeconomic issues, as well as psychological issues about assuming the “sick role.” It is always valuable to probe the roots of noncompliance. Interestingly, although patient education has “content” value (i.e., you are conveying important information to the patient), it also has “process” value in that it shows you care enough to take time with the patient. A caring, empathetic physician, research shows, leads to more compliant and better controlled diabetic patients.

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Comment #1

You know, I have learned that a good follow-up when you notice perplexity in yourself is simply to say, “It sounds like you don’t want to do all these tests. Can you help me understand what your concerns are?” It is seemingly inexplicable on the surface, but she must have reasons/fears/misconceptions etc.

Comment #2

Excellent empathy and a good hypothesis. “Routine” tests can be anything but routine to patients, especially one who has already had a tough diagnosis.

Comment #3

This is very creative and ingenious thinking. You make a point that hadn’t occurred to me, but it is very plausible, especially the aspect of exercising autonomy, when she may well feel helpless about the MD.

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Comment #1

Ha! I LOVE this comment. It is profoundly insightful, and shows just how much the medical model “controls” the interview. This is not necessarily wrong (although it can be); but it is definitely a demonstration of power.

Comment #2

Haha. Again, you are using humor brilliantly to question who is “wrong” – the “chatty” patient who doesn’t want to structure her agenda according to the physician’s priorities; or the physician who is frustrated by the patient’s humanity and life story. Of course, it is not really a question of right or wrong, but how the nature of the doctor-patient relationship is to be determined.

Comment #3

This was an adorable essay and really enjoyable to read! Your final point is an excellent one: all the information the patient is telling you matters – to the patient; and if the doctor is smart, to the doctor as well. This doesn’t mean you can’t redirect and set limits; but the patient is striving to establish a relationship of “personalismo,” so they are known to the doctor not merely as a disease but as a human being. These patients are telling the doctor about their values and their concerns and their lives. A wise doctor will figure out how to work with what she’s hearing to benefit the patient’s health.

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Comment #1

In this situation, I think it does make a difference that the patient, in a fully conscious state, explicitly stated that he agreed to accepting blood products in order to save his life and that this statement was witnessed.

Comment #2

Yes, this is very hard to understand. You probably realize that JW followers believe that, if a person receives a blood product, their soul is damned everlastingly. They are weighing life in this world vs. life in eternity. It is also true that JW tend to be a very tight-knit community, and someone who has received blood will be ostracized.

Comment #3

The physician's overriding obligation is to his or her patient. If the patient's wishes are unknown, the family must be the designated decision-maker, even if their decision violates the physician's personal/professional beliefs. But when the patient has expressly stated wishes, even if they contradict the family's desires, it is the responsibility of the doctor to honor them

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Comment #1

This is a good example of when the patient's agenda (perhaps a long planned and eagerly awaited visit home) and the doctor's agenda (address an urgent and serious medical issue) are in conflict.

Comment #2

How skillful that you elicited this "deeper" information. This makes the importance of this visit even greater.

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Comment #1

It sounds like you and your preceptor did a great job in meeting Mr. H's needs. I wonder was he on anti-depressant medication? Was he being followed by any sort of counselor or therapist? Unfortunately, these individuals are not always available because of insurance limitations. However, a team approach that provides mental health support could alleviate some of the pressures on the pcp.

Comment #2

Yes, you will see good family docs always balancing these conflicting priorities. Sometimes some patients must wait so that other patients in true need can be helped. This does not mean that physicians should not strive to be on time. But a good doctor is able to make adjustments in her schedule based on the needs of the patients.

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Comment #1

Leila, this is really beautifully expressed, and so true. It is hard to see both – the 15 min. slot AND the humanity of the patient – but if you have to err on one side, I hope it will always be the latter, despite all the institutional pressures pushing you in the opposite direction.

Comment #2

this is really beautifully expressed, and so true. It is hard to see both – the 15 min. slot AND the humanity of the patient – but if you have to err on one side, I hope it will always be the latter, despite all the institutional pressures pushing you in the opposite direction.

Comment #3

Good self-awareness. Most people would feel exactly the same – "This patient is messing up my schedule." It is what we do with those feelings of annoyance, and where they take us, that matter.

Comment #4

Excellent attention to what your patient was really telling you. The good clinician sometimes has to put together the pieces in a different way than they expected walking through the exam room door.

Comment #5

Such an important insight, Leila. It is so tempting to ignore complexity in favor of simple answers. But human beings are complex and often so are their problems. As you are no doubt discovering, a good clinician can distinguish between a truly straightforward visit and a visit that they only want to be straightforward. Good clinicians have the skill – and caring – to make adjustments in the time they spend with patients – and by doing so, often save themselves time in the long run!

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Comment #1

What are some of the reasons patients are not always honest? Possibly fear of judgment; possibly a desire to present a certain image; perhaps to manipulate?

Comment #2

Feeling manipulated is a very bad feeling. Thknk about how else you might respond rather than “giving up,” which is a completely natural response, but of course will not be in the best interest of the patient – or yourself.

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Comment #1

Heartbreaking, but how incredible that she could open up like this to her physician – and that he took the time to listen to her.

Comment #2

I think when confronted by such sorrow and need, we all feel helpless and want to do something. However, as you go on to say, what the patient really wanted was her husband restored, tragically an impossibility. After that, what she wanted was someone to witness her pain, and you and Dr. Pardo did exactly that.

Comment #3

Doctors are programmed (and have personalities that like) to fix problems. That’s a good thing. But not every problem can be fixed – and when we try to fix things too superficially, we don’t fix anything at all and just create more misery. As a physician, you’ll discover there are plenty of things about your patients you can’t fix. But you can take a few moments now and then just to listen to their problems. That in itself is therapeutic and may give them hope.

Comment #4

If you haven’t already had the opportunity, shadow Dr. Osborn sometime in the ED. It’s a different kind of relationship, not as deep as a continuity relationship, but meaningful nonetheless.

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Comment #1

Very skillful of you to return to this question. Financial constraints are often extremely stigmatizing and many people are reluctant to talk about them. When broaching a delicate, potentially

embarrassing topic, what are your ideas for how to encourage patients to elaborate, so you will be able to get the information you need?

Comment #2

Both very good learning. Psychiatric (or even just "life") problems may present as physical symptoms; but you always want to rule out physical causes as well.

Comment #3

Yes, as above it can be hard to get strangers to open up. There is no fool-proof method – but treating them with respect, normalizing their discomfort, empathizing with them, and explaining that the information may help you take better care of them.

Comment #4

There are always time pressures – and it is always challenging to figure out how to have meaningful interactions with people when you rarely have enough time. Right now, as a third year student, this can seem almost impossible. But you've probably already seen examples of physicians who've developed the skills to efficiently but compassionately establish rapport, earn trust, and engage patients around difficult topics. Keep at it.

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Comment #1

It sounds as though you see her responsibility for the poor choices she made that led to this situation; but that you do not want to judge her for these choices. You are both frustrated and compassionate. Do you feel that the frustration might interfere with optimal care of the patient; or do you think it could be managed if, for example, you were her pcp? How could you keep these two emotions in balance?

Comment #2

I really like your phrase, "this may be the beginning…" Dealing with chronic pain is extremely difficult and is definitely a process. It requires patience on the part of both patient and doctor.

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Comment #1

You make an important point that we cannot generalize about people's beliefs or expectations based on ethnicity or cultural background

Comment #2

Sounds like the surgeon did an excellent job of navigating between the son's fears and his legal – and perhaps moral – obligations as well.

Comment #3

Very good point – the time pressures of the clinic likely worked against the surgeon's decision, which make it particularly admirable.

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Comment #1

This is exactly what happened and it is a typical dynamic with a drug-seeking patient. You cannot take it personally, you still did the right thing to listen empathetically and try to understand his perspective. But realizing that there is another agenda operating, you also have to be firm in your boundaries.

Comment #2

This is an interesting insight. Although it was difficult to deal with this patient for a few days, you imagined that being his mother would be much more frustrating and distressing. This realization gave you some perspective on your own interactions with this patient.

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Comment #1

Great awareness of this countertransference. These dynamics bounce back and forth all the time between doctors and patients; and the best way of ensuring that they work to the advantage of the doctor-patient relationship is to be AWARE of them.

Comment #2

Another great observation. This is a common phenomenon, and as you correctly note, it effectively silences the patient's voice.

Comment #3

It is very easy to lose important information if you are not attending carefully, with all your senses, to the entire experience of the exam room. It is difficult, but not impossible to do so, even when you are the physician.

Comment #4

In almost all cases, it is preferable to use a professional interpreter rather than a family member. Family members can provide valuable perspective on patient's problems, but of course they have their own dynamics that can affect the quality and nature of their translations.

Comment #5

Excellent awareness of your own emotions as well as the patient's. In this case, the countertransference you experienced as a result of your grandma's language barriers worked to benefit the patient by making you more sensitive to her plight of isolation.

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Comment #1

Think about how you could respond to the pt's main agenda – i.e., seeing Dr. Florio. Maybe empathy – "Sounds like you really want to see Dr. Florio." Bonding: "I love Dr. Florio too." Or associated magic: "I work with Dr. Florio. She's my teacher,"

Comment #2

Great awareness of the multiple frustrations – lack of interpersonal connection AND lack of ability to complete your medical task. I suspect over time, if both of these remained priorities for you, you would develop ways of both connecting (clearly the patient had formed some sort of connection with Dr. F) and with accomplishing the PE and Hx in as successful a manner as possible.

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Comment #1

Of course, this is completely understandable – when someone confronts you aggressively, the impulse is to defend. However, it is also true that he ust have felt safe enough to trust you with his honest emotions of irritation and frustration.

Comment #2

so perceptive of you. Even with a disease as dire as cancer, the patient still has goals that are important; if these are ignored, the entire treatment regimen may be in peril, as you discovered.

Comment #3

in this dimension of care, you were really functioning as the team leader. You knew the patient best, understood his frustration best, and could act as an intermediary between patient and team to agree upon common goals and a plan of care. It shows just how important a medical student can be!

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Comment #1

Interesting. This might be due to individual differences in physician comfort levels. It might also be due to trying to avoid the cost of a specialist referral that would not be covered by insurance (or if the patient were self-pay).

Comment #2

In my view, your thinking is quite sound. I cannot comment on whether the patient's pain should have been controlled adequately on the non-opioid meds, but if she had been taking vicodin for any amount of time, this is now a problem in itself.

Comment #3

It is true that many – perhaps the majority of - patients do not abuse pain meds. It is always a good idea to check the op ioid registry to make sure there is no evidence of overuse.

Comment #4

These are all excellent points – often socioeconomic factors do matter a lot more than culture. It is class, more than culture per se, which is the biggest limiting factor in healthcare.

Comment #5

Yes, "demanding patients do things our way" often results in simply losing the patient. At the least, these issues should have been explored honestly with the patient, so you could have confirmed your (excellent) hypotheses and worked with her to develop an appropriate plan. This is not the responsibility of the 3rd yr student, but an attending should certainly realize the importance of exploring real-life circumstances that might make an "ideal" treatment plan unrealistic.

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Comment #1

Yes, I imagine you were seeing the difficulty of this situation from all sides – the patient terrified of being "shunted aside" into a nursing home, and clearly afraid of dying; the daughter beyond her limit in caring for her mom. A tough situation, but a wonderful example of family medicine!

Comment #2

Again, a terrific comment Matt. Her cantankerousness may still be frustrating, but now you understand it as a part of this woman's life story.

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Comment #1

This is something that is hard to promise, but at least you heard him, which is also very important. This is what he was telling you – "Because I'm homeless and have no insurance, I fell through the cracks."

Comment #2

This must have been so upsetting, so frustrating, especially when you'd made such an effort to "save" him this time around.

Comment #3

I'm glad you're wondering about this. You're right, of course, you can't always succeed with every patient. But it is worthwhile to use apparently inexplicable behavior as a starting, rather than an ending point. For example, what might make a patient not follow up with important medical care? Could it be mental health/drug use issues? Could it be the transient nature of the patient's life? Could it be denial? Until you can start answering these questions, you won't be able to figure out if you can help or not.

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Comment #1

It is very easy to fail to address the patient's most pressing question when, to the physician, it does not seem important and/or does not make sense and/or in the dr's mind has been dealt with, especially when harried and pressured. However, it often complicates the interaction to the extent that MORE time is lost, in addition to loss of trust and exacerbation of patient annoyance.

Comment #3

Indeed, this would be a shocking and, from your perspective, totally unpredictable transformation. Here you see the patient attempting to act as her own physician, ordering her own tests, because her confidence in her real doctors has been damaged.

Comment #4

Good for you. There is already one panicked person in the room (I'd suggest the pt's anger is really a cover for her fear and distress), and adding more emotionalism to the situation, however understandable, will simply make a difficult situation worse.

Comment #5

Good empathy. Sometimes when expressing empathy, before going on to explain WHY the pt's fears are unfounded, it can be helpful to pause, and ask, "Do I understand you>" to make sure the pt sees you REALLY get their perspective.

Comment #6

This is a medically sound and logical point. But if you are dealing with the pt's emotions – broken trust, feelings of fear and panic – logic may not prevail. In such a situation, the underlying issues need to be addressed.

Comment #7

This is a very understandable response, but unfortunately is not going to do anything to reassure the patient. The computer screen is often a refuge, yet in messy human interactions, it rarely holds the answer.

Comment #8

Ha-ha. I'd like a nickel for every time a doctor had the impulse to run out of an exam room! Buddhists teach that in many situations, the most courageous practice is to "Stay, just stay." In other words, don't run away (either literally or emotionally), figure out how to stay connected with your pt, and keep working the problem.

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Comment #1

Good insight. This patient was cooperative and pleasant, but her history was so complicated it took a long time to assess it thoroughly.

Comment #2

You are struggling here with the conflict between the pt's agenda (tell her story) and your agenda (get the hx in an efficient manner). I think on the whole choosing the pt's agenda is the right move to make.

Comment #3

Good insight, it is all about finding a balance. Both are important. There are many pressures to prioritize efficiency over all else. In fact, as you wisely state, you need to be thorough, convey to the patient that she is heard and understood, and still be efficient and productive. You can't always combine all of these in a single visit.

Comment #4

This does make it harder because you may have to choose between efficiency and compassion. But, for example, if the patient had been suicidal, you would really want to have elicited this information, even if it had slowed you down.

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Comment #1

While this is important information to have, I hope it was presented in a way that did not lead you to judge or make assumptions about the patient.

Comment #2

Excellent that you are familiar with this approach. I hope you will be able to describe for your classmates how you tried to help him engage with his own health.

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Comment #1

Excellent that you went beyond the prevalent idea that patients who do not follow up "don't care" about their health. You discovered that his behavior was the result of lack of understanding rather than lack of caring.

Comment #2

Excellent job of getting to the bottom of what motivated the verbally abusive behavior. This understanding does not excuse the behavior (which deserves limit-setting if it recurred), but it gives much insight regarding how to address the patient's real concerns.

Comment #3

You are so right. For those immersed in the healthcare system, it is familiar and appears easy to navigate. But for most patients, it can be completely bewildering.

Comment #4

This is another superb insight. It is very easy to lose track of the overall picture, with the result that the patient does not receive optimal care.

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Comment #1

Oh my goodness, this is shocking. I wonder how your attending respond. Did s\he accept this kind of behavior from the patient?!

Comment #2

As well it should. When there are fundamentally different levels of healthcare (the 1% and everybody else for example), you will never have equity; and doctors become employees, which can harm both the doctor AND the patient.

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Comment #1

This is sage advice – it speaks to the importance of paying attention to all the emotions floating about in the exam room – the patient's, the family member's, AND your own. Otherwise it is likely that, without attention, these emotions will enter into the encounter in unexpected and problematic ways.

Comment #2

Especially at this stage of your training, it is a very good strategy to create a little "time out" for yourself to assess what is going on. As you become more experienced, you will also learn ways of quickly and unobtrusively making such calibrations while remaining present with the patient.

Comment #3

Third year is so overwhelming and so different from anything you've experienced to date. From listening to a lot of medical students over the years, I can say it is also a time of self-doubt and self-

questioning. Therefore, the patient's rude and hostile behavior (and yeah, you have to cut him a little slack, he WAS psychotic) may have inadvertently touched a nerve.

Comment #4

Very nondefensive and wise. Even when people behave inappropriately or unfairly toward us, it is valuable to ask ourselves, is there ANYTHING I can learn from this feedback? Maybe not, but often I find myself answering in the affirmative.

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Comment #1

Once you know the back story, her response makes a lot more sense. And as we discussed in class, everyone has a story, even when we don't know it.

Comment #2

What a great and generous conclusion. You are so right – patients need your knowledge and care of course, but it is always true that their allowing you into their lives IS a privilege.

Comment #3

This is such an important point! Although we don't know the "back story" between this patient and her doctor, it was distressing to realize that her most serious issue, i.e., abuse, apparently had not been addressed. Just a good reminder that the "easiest" agenda item is not necessarily the most important; and that physicians need to be willing to plunge into messier domains when the well-being of the patient is implicated.

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Comment #1

Excellent – it is easy to become frustrated and judgmental in response to these attitudes. I specific cultural factors are playing a role here that we understand very little about.

Comment #2

Let's hope so. The first step will be to understand this patient's thinking better. Next will be to offer him other ways of thinking about himself. I suspect that underneath the bravado this young man may be lonely, isolated, struggling in a foreign country not always sympathetic to Muslims. A broader approach that considered how he is doing overall in this country might earn his trust and provide a context within which to consider dietary change, alcohol consumption, and smoking habits.

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Comment #1

That's true. I wonder what you might consider, once you've ruled out rare diagnoses that might have this presentation? For example, might you consider depression? Somatization disorder?

Comment #2

Good for you for recognizing that there may be a cultural component here. For one thing, the way patients express pain is certainly culturally influenced.

Comment #3

Good question. It seems to reflect your frustration that patients with this presentation are time-consuming, and you might feel you can't do anything to help them.

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Comment #1

Speaking only as someone who's had 2 total hip replacements, typically post-surgery there is very little pain. Of course, every patient is different.

Comment #2

And it can be some of both. A patient can be in pain and also addicted. And of course addiction itself creates a kind of pain.

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Comment #1

The question of how trustworthy authority is established is an intriguing one. We assume "physician advice" based on EBM and RCCT is most trustworthy. But other people trust their family, their cultural traditions, the internet etc. much more than doctors. How to address this difference is complex but obviously important in providing optimal clinical care.

Comment #2

I found your arguments very persuasive, but obviously the patient did not. This might be a point at which to broaden the conversation, rather than focusing exclusively on whether HbA1C should be 7 vs. 7.4. What else might be going on here?

Comment #3

I think this is very insightful. I too feel something more might be operating. Perhaps the patient feels helpless about his health and is determined to reestablish control somehow. Maybe the support groups that have become such a mainstay since his wife's death endorse these magazines. In any case, you are right that the most important thing is not whether the patient agrees to continuing his dose of metformin, but to find out what he wants. In other words, what does a lower HbA1C mean to this patient? That he is "healthy"? That he is "beating" his diabetes? That he's not going to die? It may be hard to do in 15 min but this is what's important to providing good continuity care to this patient. Otherwise I suspect he will continue to power struggle around this or similar issues.

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Comment #1

Thank you for acknowledging this difficulty. It is true for most people, but most people can't admit it, so therefore have a lot of trouble getting past it.

Comment #2

Yes, there is a strong impulse to judge the parent as ignorant, irresponsible, neglectful etc. Recognizing this reaction is important, so it doesn't unconsciously influence your interactions with the patient.

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Comment #1

Yes, I agree with this; as you know there is a fine line between saying, "This is the problem" and "I think it could be this, but it might be that, and the person who can answer definitively is the attending."

Comment #2

Of course, it is wrong for the father to be impatient; on the other hand, when kids are sick, parents get a little crazy, and are determined to get the best care possible for them. The father may have questioned your youth or inexperience, but was not able to do this in a polite way.

Comment #3

I’m sure you’ve seen this on the wards many times – when one team offers the patient one opinion, and another team suggests a different one. It is distressing and confusing. As healthcare moves more and more to team care, it is important that all members of the team be on the same page for the sake of the patient.

Comment #4

Good advice – when you are for all intents and purposes the “doctor” in the room, and the patient/family member is pressing you for answers, it is easy to go beyond your expertise. This can cause problems, as your attending recognized.

Comment #5

It sounds like your attending handled this very well – a good teacher, not focusing on shame and blame but helping you reconsider how to handle such situations in the future.

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Comment #1

Knowing when and how to focus an interview is indeed a skill that you can acquire with practice, so long as this is done within the context of respect for and commitment to the patient’s wellbeing.

Comment #2

Patients like JP are sometimes called heartsink patients, because of the feelings they evoke in their physicians. Yet, although this reaction is understandable, it’s important to remember that patient care should be focused on the patient not the physician. When a shift occurs, the physician must know how to manage this emotional response so it does not adversely affect care.

Comment #3

I hope I am not speaking out of turn Molly when I say good for you. It is of course necessary that the “system” of clinic flows smoothly – patients move through their lines, residents move through their lines and everyone is out by 6:00. But efficiency is not the only value, and sometimes the patient’s story matters more – infinitely more. Being able to see this, and make the necessary adjustments, in my view is the sign of a good doctor.

Comment #4

It sounds like you had an outstanding role model in this instance, who was able to set limits while at the same time sending a clear message that she was NOT trying to get rid of the patient, but rather was committed to his care.

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Comment #1

Very nice awareness in your comment in class re how throw-away comments made by attending, residents, nurses can really shape your thinking/expectations/attitude about a patient. Of course they may well be right, but it's important to also hold out the possibility that the patient is "more" than "demanding," "hostile," "difficult."

Comment #2

And this made her difficult because…? Was it difficult to reassure her? Did it compromise her HPI? Sometimes emotions are "contagious" – an anxious patient makes us feel anxious, then we find the interaction more "difficult."

Comment #3

Patient resistance – the bane of the busy physician's life. Sometimes it helps, rather than trying to persuade the patient to your way of thinking (Follow my advice, gosh darn it!), to simply be curious about "resistance." Where does it come from? In this case, it may stem from the patient's depression, which often makes people feel hopeless about implementing any kind of change. Treating the depression might soften the resistance. Of course there may be other reasons as well, and understanding them better (even though in the moment more time-consuming) will help you craft a more effective treatment plan.

Comment #5

Sometimes, when someone keeps repeating something, it's because they don't feel heard. That doesn't mean you haven't been listening, only that you haven't fully conveyed to them that you understand them. Using active listening skills such as paraphrasing (it sounds like what's upsetting you is…) and empathy (this seems like such a hard time for you) can help show the patient that you are paying full attention.

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Comment #1

It is always interesting and usually informative how patients describe the side effects of medications, even if it not a listed reaction.

Comment #2

This discussion could be tangential to the “purpose” of the visit. However, we know that uncomfortable side effects are one of the leading reasons why patients are not compliant with medications. So exploring this and seeing if there is a way to mitigate this sensation seems important.

Comment #3

In this case, you are translating the patient’s rather lyrical and “spiritual” language into “scientific” language. Sometimes that makes sense – you are bot describing the same phenomenon using different language – and seomtimes the patient is having a unique reaction that still deserves attention.

Comment #4

Do you think that, after understanding better what might have been going on with the patient, you could discuss these reactions in a way that could make her more willing to persist with the new medication regimen?

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Comment #1

When patients feel “healthy” it can be very hard to believe they have a chronic, life-threatening disease that cannot be cured. Easier to ignore it. It is this “gap” that must be addressed.

Comment #2

These are all compelling stories, also terrifying ones. I wonder how the patient responded. Did he connect with these patients or did he reject the similarities? What other stories might you tell? What do you think the patient needs from you – maybe some balance of fear and hope?

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Comment #1

Excellent attending to the totality of your patient, not only his chief complaint. I wonder what you concluded from these observations (patient with CHF still smoking?; annoyed to answer questions designed to improve his health?)

Comment #2

What did you learn about your patient from this question? (did he think there was a simple solution you were ignoring? Did he mistrust your expertise because you were a medical student?)

Comment #3

These circumstances can be so frustrating. It is always difficult to help an angry patient. And it is easy to feel frustrated or even angry yourself, when all you're trying to do is help. That having been said, I'm interested in your thoughts about why the patient was angry. Do you think he might have felt no one was listening to him? Do you think he might have been afraid about the implications of CHF, and longed for a simple pill to "fix" him?

Comment #4

Ouch. This must have been pretty upsetting. I'm curious what your attending's reaction was. And your reaction? Sometimes patients become angry and sometimes they walk out and sometimes there is nothing you can do to prevent this outcome. Still, sometimes there can be ways of dealing with anger that diffuse it and that allow the encounter to move forward.

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Comment #1

It is true that this may not make much sense medically and I do understand that the resident is laughing out of his/her own sense of frustration and helplessness. Still, I wonder what other responses might be possible after learning about the husband's thinking.

Comment #2

Exactly. There is a huge difference between "telling people what to do" and inviting them into the thinking that guides the doctor's recommendations. The latter is a much more effective method of pt education. Sadly, drs sometimes make judgments about who can and cannot benefit from such more comprehensive explanations based on variables such as age, ethnicity, or formal education.

Comment #3

Indeed, you deserved to feel very rpoud of your actions. You truly had an impact on this patient's life.

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Comment #1

I don't think that anorexic or bulimic behaviors can result in involuntary psych hospitalization UNTIL the life/wellbeing of the patient is actually in jeopardy (I can't tell if that was the case with this patient, but I suspect not) . Nevertheless, you are absolutely right that the patient is certainly inflicting harm on herself.

Comment #2

I wonder if it would have been appropriate to strongly urge her to confide in her mother – or if not the mom, a school counselor or some other trusted adult. It seems unlikely to me that this 16 yo can manage anorexic/bulimic behaviors on her own, especially given their allure. The worry of course is that dabbling in these dangerous behaviors will escalate.

Comment #3

I agree. It is a difficult situation. You do not want to violate her trust, but you do want to keep her safe. It sounds as though you tried to strike an appropriate balance.

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Comment #1

This can be a difficult situation for the medical student – or the physician! – to handle. No explanation for the pt's distress has emerged. It is important at this point to relax, be interested in a situation that is not clear-cut, and be ready to probe further.

Comment #2

Excellent questions to be asking yourself. These are indeed sensitive issues, and how you broach them is really important.

Comment #3

This can be a hard place to be, and it is a place that doctors – as well as medical students – sometimes find themselves. An answer is not always immediately forthcoming; and sometimes the desire to reach resolution, which is so strong in medicine, can lead to premature closure. In this case, issues of possible eating disorder and cutting are complex problems with no easy solutions. Ideally, this patient can be referred to benefit from appropriate resources. But for this to occur, the patient will have to feel understood and valued by her primary care doctor.

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Comment #1

A great approach – rather than upend your patient's dietary patterns, look for ways to adjust and adapt them in a healthier direction

Comment #2

I think this mutual appreciation – even pleasure in the encounter – is the mark of a successful interview. You both truly did learn from each other. Equally important, you established trust and developed connection.

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Comment #1

I would be very interested to understand more about how the intern did this; and whether not being a native Spanish speaker introduced complications in delivering this very difficult news.

Comment #2

This is a great question, probably the key starting point. What is the patient's understanding? Obviously in this case, he has not grasped the severity of his situation. It is important to think about why that can happen, and how better communication can be achieved.

Comment #3

This is quite possible. However, given the language limitations and the dire news being imparted, it is completely understandable that the patient didn't fully grasp the situation. There are many ways of ensuring better patient understanding when being given very bad news; but it is likely that because of time and language constraints the intern was not able to use these fully or at all. Tragically, the result is a patient who does not yet understand that he has inoperable cancer and that he will die.

Comment #4

It is a little disappointing to see the burden of problem-solving this situation falling on the 3rd year student, but good for you for insisting on the right thing here. It is simply not ethically right for a person to be given a terminal diagnosis by people who are not fluent in his language. This becomes obvious when you reverse the situation and imagine being told you were going to die by someone in broken English who made all sorts of mistakes and could not understand your questions.

Comment #5

Denial is a very interesting concept. Of course, from one perspective, it is simply a descriptive psychiatric term denoting "a defense mechanism in which the existence of unpleasant internal or external realities is kept out of conscious awareness." However, the term sometimes carries a

negative connotation, because while denial temporarily protects the patient, it complicates the life of the physician. Even while attempting to resolve a patient's denial (which of course can stand in the way of treatment, and prevent patients from dealing with important life tasks), it is important to simultaneously recognize just how understandable and in a certain sense "logical" a response it is.

Comment #6

This expectation, however unrealistic, is what many, if not most, patients bring to the doctor's office. Of course, what we all want is to return to the life we once had – and hearing that this may no longer be possible may take some time to absorb. It is also a hard message for a physician to acknowledge ("I can help you, but I can't cure you/save you") – and this often leads to unclear communications that implicitly overpromise what can be achieved through medicine.

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Comment #1

Both good observations and good caution. We always want to be thinking actively about what is going on with patients on multiple levels; but we also want to remember that it is hard to understand another's life quickly.

Comment #2

I agree. This can be hard to do, if another's cultural norms violate your own beliefs; but unless these norms are actually harmful (and of course that can be hard to define), you will likely just alienate the family and lose the patient by challenging their culture too quickly.

Comment #3

This is also important – while not overtly challenging their cultural preferences for "plumper" women, to use science to reassure them that the daughter is completely healthy and of normal weight.

Comment #4

It's great that this turned out so well. Most importantly, a relationship with patient and her family was established, which will allow her doctor to continue to monitor these issues.

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Comment #1

It’s ironic that we do all we can to ensure that health care professionals do not discuss patients in public places, yet here are family member/patient asking you to engage in a medical discourse in an elevator!

Comment #2

This is an interesting twist. The patient was friendly and glad to see you. He is obviously suffering and has a poor prognosis, yet he is also verbally abusive. I wonder how or whether this changed your feelings towards him.

Comment #3

So because of your background, you could empathize with the courage it took for her to speak up, and share the frustration that not more was done to help her. I believe there are groups specifically aimed a domestic abuse outreach for Muslim women, but I don’t know whether this exists in OC. I wonder what you think would have been the right way to handle this situation. Let’s discuss in class!

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Comment #1

This is not uncommon with patients who have chronic disease and significant levels of pain. It becomes very challenging to sort out what is legitimate pain and what is drug-seeking.

Comment #2

Sometimes you can end up talking about the wrong thing – i.e., arguing about whether or not to switch to the long-acting opioid. Sometimes it helps to really listen to the patient’s concerns and fears before moving to confrontation.

Comment #3

Both are part of your relationship with this patient; and both deserve attention. The question becomes how you can work with these feelings to ensure the patient receives the best care possible. Too much frustration can make you alienate the patient; too much sorrow can make you collude with the patient. Yet both in balance can help you chart the best possible course given these very difficult circumstances.

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Comment #1

Ouch. I am sure this physician was very frustrated and helpless. I think there are other ways to handle this situation. Changing doctors will not help the patient in any way, it simply removes the patient from the doctor's awareness.

Comment #2

Yes, I think this is the key. If you feel you've tried every approach – listening, understanding the pt perspective, motivational interviewing, treating the depression, sharing your frustration etc. – then there may be times when you terminate a patient for their benefit. From your description, this does not sound like one of those times.

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Comment #1

It is very obvious some of the challenging aspects of not having adult children involved in end-of-life care, including the ones you mention above. I wonder if you can think of any potential downsides to having adult children responsible for the care of their aging parents.

Comment #2

I agree with this conclusion; however, sometimes even younger caregivers become overwhelmed with the responsibilities of care, physical, emotional, and financial. It is this possibility that makes many elders want to avoid burdening their children. Sadly, elder abuse occurs both in nursing homes and when seniors are cared for by relatives. Ideally, we can draw on the best of both cultures, and provide services to support overstretched family members who want to give their parents personalized, loving care at home.

Comment #3

At the best, this is theoretically possible. However, most older persons surveyed want to stay in their own homes until they pass.

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Comment #1

You are making a good distinction between language skills and cultural competence/sensitivity. Knowing a language is just a first step.

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Comment #1

This illustrates how diet is very much a family affair; it is very difficult to succeed in changing just one person's diet in a family. Also, as your patient, intimated, food has all sorts of positive associations going back to childhood, another reason why various foods are so hard to give up.

Comment #2

Indeed, "noncompliance" should always be the START of a conversation with the patient, not the end. No patient should ever be dismissed because they are noncompliant. This is an invitation to understand where the obstacle lies, and how it might be overcome or circumvented.

Comment #3

And another option is to consider family-based change – at least within those family members with whom the patient has regular contact. Often by finding the "key" contributor – the person who does the most cooking, or has special authority within the family – this can be less overwhelming than it seems.

Comment #4

Fantastic – it sounds as though you got the patient to buy-in, once you'd won his trust and shown that you were not trying to disrupt his entire way of living and his family ties.

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Comment #1

Great you recognized this connection, although you may have very different life circumstances. I wonder if you shared this commonality with him – it might have put him a bit more at ease.

Comment #2

I wonder if this hx might influence his responses? Perhaps the pt is disengaged from his healthcare? Perhaps he is embarrassed/ashamed that he has not made greater progress toward managing his diseases? Perhaps he has a learned helplessness regarding these encounters with physicians?

Comment #3

These are hard questions to ask in a way that doesn't suggest to the pt that he is a "bad" pt. Let's talk in class about approaching this sensitive topic (as it's clearly important to do).

Comment #4

This may be part of the problem. It may also be the case that, compared to other serious things in his life, the fact that it hasn't "bubbled over" to extreme seriousness means that, to him, it truly isn't yet that important.

Comment #5

Excellent awareness that this is not simplistically a pt who "doesn't care" about his health, but someone who is likely struggling against multiple systemic factors that may mitigate against adherence to the ideal medical regimen.

Comment #6

In my view, you've extracted the right lesson from this difficult encounter because you were willing to acknowledge that perhaps your intervention hadn't been entirely successful. This says less about the quality of your interaction – which sounded very good – and more about the difficulty of the problem at hand. However, unless the physician is honest about what his/her pt is struggling with, real progress toward change is unlikely.

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Comment #1

Two words – universal healthcare. It is this kind of injustice that leads to so many health issues in our patients and such disillusion and cynicism in our doctors.

Comment #2

Or that at least it was better than nothing. It's a very interesting, although as you say dangerous, example of a family-centric approach to healthcare.

Comment #3

You and your attending took advantage of your cultural knowledge to try to improve the patient's health situation. As you know, sharing of meds is not only a result of lack of knowledge but often reflects socioeconomic realities. Acknowledging that you have a chronic, incurable disease with many frightening long-term complications can be overwhelming when you are struggling with how to provide food and pay rent.

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Comment #1

Excellent insight – food and culture are often intimately connected, and very hard to disentangle.

Comment #2

Exactly – well done. Even though this took more time initially, it will likely save many fruitless future encounters; and actually benefit the patient.

Comment #3

All of this is absolutely true. In addition, by taking time to understand your patient better, you are also conveying to her that you care about her as your patient and are genuinely interested in helping her.

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Comment #1

Indeed, it is hard to know how to respond. At the same time, your patient is telling you something invaluable about the way he understands the world.

Comment #2

Is he wrong? Is there a chance that chemo will give him additional meaningful QOL? If so, then this points you down one road. How might you be able to incorporate what you've learned about his health beliefs to encourage him to think about chemotherapy from a different perspective? If on the other hand chemo is not going to materially change the outcome, then your pt is telling you about his wishes and these should be respected.

Comment #3

Ah, this is key. This has nothing to do with God's will, and everything to do with his associations to the dreaded word cancer. This is where you might be able to make a dent.

Comment #4

This also is a very important awareness. Knowing someone's cultural "label" can sometimes point us in useful directions… but not if it leads to assumptions. We need deep understanding of the pt, and while that may be influenced by family, culture, socioeconomic status, class, etc. it is fundamentally a very idiosyncratic constellation of factors that can only be discovered, as you wisely observe, by truly listening – not arguing, not persuading, but engaging in respectful dialogue.

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Comment #1

I agree with you that the chronic pain patient is “dreaded.” It’s interesting that this puts the focus on the physician, and how uncomfortable it is to have to either a) set limits on a meds-seeker or b) confront one’s own helplessness and the limits of medicine. It’s worthwhile to think as well about what it is like to be addicted to pain meds and/or to have legitimate pain for which there is little relief. It’s a very hard dynamic on both sides, and when they come together, good things rarely happen.

Comment #2

This is a great question. I don’t have an answer, but I hope we can explore. How does knowing his past history change your view of him? Suppose you didn’t have this information, what difference would that make? What are your obligations to him as your patient regardless of his criminal history?

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Comment #1

Denial of depression and suicidality can be common in teens AND their families, and can be influenced by culture as well. This is due in part to the stigma still associated with mental illness; as well as, in some cases, unfamiliarity with signs and symptoms.

Comment #2

Exactly. The sense of shame associated with mental illness is particularly high in this culture, and is often influenced by generation as well.

Comment #3

Might there be any way to work with the expectations for the eldest child to care for the younger sibs and be a good role model to encourage her to address this serious problem?

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Comment #1

Interesting. This highlights the discrepancies that can exist between the doctor’s agenda (address the serious medical condition of infected mitral valve) and the patient’s agenda (ensuring the economic viability of his shop)

Comment #2

Language differences are always frustrating in healthcare, and especially so when the condition is serious and there is a so much at stake. I’d be interested in learning more about the “best efforts.” I can imagine that it would be challenging to explain this medical condition to someone who hadn’t been to a doctor in 20 years.

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Comment #1

This dynamic can be frustrating to deal with. It sounds like you had a good strategy for engaging your patient, but it wasn't working.

Comment #2

Although the phone interpreter is very helpful, as you know it can be awkward and even intimidating to communicate through this technology. So while this may not fully explain the husband/wife relationship, it may have been a contributory factor.

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Comment #1

This dynamic can be frustrating to deal with. It sounds like you had a good strategy for engaging your patient, but it wasn't working.

Comment #2

Although the phone interpreter is very helpful, as you know it can be awkward and even intimidating to communicate through this technology. So while this may not fully explain the husband/wife relationship, it may have been a contributory factor.

Comment #3

You are looking for ways to establish direct connection with your patient – excellent! There is no one way to guarantee this, but there are a range of approaches. Sometimes it helps to positively acknowledge the family member and make her feel safe – "I can see how much you care for your husband. Thank you for all the information you've provided. I'd like to hear your husband's ideas as well; and then maybe I can get your thoughts as well." At the other end of the continuum, you can politely ask a family member to leave the room (performing a PE is often a good excuse ☺). The most important thing is to try to understand the wife's perspective: Does she see herself as helpful? Does she have a controlling personality? Is she afraid her husband can't communicate effectively on

his own? Once you get some insight about this, you will be able to figure out how to address the problem most effectively.

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Comment #1

Another perceptive comment. Countertransference, whether positive or negative, is often present in the patient-doctor encounter, and awareness of how it might be operating can help ensure your interaction promotes the patient's best interest.

Comment #2

And this is where the challenge arises – the conflict between efficiency and kindness. You couldn't possibly kick your grandma out of your exam office! ☺

Comment #3

This is an excellent point. In allocating your time, you must consider not only the patient in front of you, but also all the other patients waiting that day.

Comment #4

A wise attending – when a pt is not seriously ill, there is a tendency to space out their appts as far as possible. For many pts, this works perfectly, both financially and in terms of busy schedules. But for a lonely old lady, it will be very reassuring to her that she has regular access to her physician. Paradoxically, this scheduling may make it less likely that she requests frequent, unscheduled visits.

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Comment #1

I really commend your persistence and flexibility – You sensed there might be a larger story here and were tenacious (yet respectful) about eliciting it. Although usually gynecomastia

Comment #2

Although usually this condition is medically benign (it can be associated with testicular cancer, which is another reason it is so great you did not just "move on" from this reluctant kid) it can be psychologically and socially devastating.

Comment #3

Indeed. I was really impressed by the way in which you reached out to this young man, lessening the emotional distance between you and him, and offering yourself as a trustworthy source of support and assistance. Very nicely done!

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Comment #1

These discrepancies – between “check-up” and “numerous medical problems”; between “pleasant” but “incoherent” – can be very unsettling and frustrating.

Comment #2

Yes indeed, this might well have been the result of her CVAs; but it is also true that linear presentation is influenced by cultural forms of narrative.

Comment #3

Excellent – so by consulting with your attending, you discovered the “reason” for the visit; and could develop an appreciation for the “extra-medical” factors that can influence scheduling an appointment.

Comment #4

Interesting observation. From the student/doctor’s perspective, control promotes the agenda of making the differential diagnosis and formulating a treatment plan. Physician control is important for focus and efficiency. However, it must be balanced by the patient’s need to tell her story, even incoherently and chaotically.

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Comment #1

I’d be curious about the long-term treatment plan the attending has for this patient – just refilling benzos and Ritalin endlessly? The patient may be happy with her care, but perhaps she doesn’t know – or is frightened of – what might be more helpful. It is very interesting to me that this is a patient with apparently plenty of financial resources whose underlying problems are not be addressed in the healthcare system. I would hope that at some point in a continuity relationship, the doctor would have the courage to confront the patient about whether these medications were really the answer to her problems.

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Comment #1

And here it is. Rather than worrying about possibly life-threatening conditions, this patient is forced to worry about medical costs. It shows that ACA, although hopefully moving us in a good direction, has not solved gaping holes in our healthcare. I can think of many times when I've seen a similar scenario play out in clinic.

Comment #2

You did the best you could, negotiating a compromise, but it is hard to swallow that people living in this country receive different standards of care.

Comment #3

This is unfortunate, although not atypical. When such painful situations are not honestly discussed, it is easy to cope by becoming hardened or even blaming the patient for "not caring about her own health."

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Comment #1

If her husband was acting as the interpreter, it might have been difficult for her to say she DIDN'T want a full code, and DIDN'T want to keep him alive as long as possible. I also suspect there were cultural factors at play here as well.

Comment #2

Yes indeed, Mrs. S communicated her grief in despair to the team in ways that required no language. I'm very admiring that you were able to recognize yourself in her – just two vulnerable human beings.

Comment #3

This is such a moving realization on your part. This sort of suffering is so profound, and I think the only thing that alleviates it (even if only slightly) is when it can be shared.

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Comment #1

As we discussed, reporting emotional abuse is an option physicians can exercise (as opposed to evidence of physical abuse, which is mandatory reporting). The risks/benefits of optional reporting should be weighed carefully.

Comment #2

It was very important that you realized this dimension of the situation. As Dr. Khwaja pointed out, "culture" is not an excuse to ignore mistreatment or abuse, but it is important to take cultural context into consideration in evaluating your next steps.

Comment #3

Your own cultural background may make it easier for you to understand both the patient's ambivalence and appropriate ways of helping her. I admire that you realize that the person of the physician is not irrelevant in the clinical interaction.

Comment #4

Excellent thought. You realize that culture is not monolithic or static, and that within a given "culture," many different views prevail. These views are also sometimes influenced by generation.

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Comment #1

Very good. When you encounter something that surprises you in medicine, whether a lab result or a patient attitude, take a moment to reassess, to rearrange what you think you know about the patient.

Comment #2

Excellent self-awareness. Learn to pay attention to the uncomfortable moments in medicine. They can teach you a lot - both about your patient and yourself.

Comment #3

How wonderful. Your patient has just given you his life philosophy. This information will be so helpful to you in figuring out how to take the best possible care of your patient and developing a treatment plan that he might actually follow.

Comment #4

And I would just add, "not yet." It might be a tad ambitious to expect that you could change your patient's entire outlook with one well-chosen metaphor. But I suspect you've planted a seed.

Comment #5

This was actually great! You showed you heard what the patient was saying about surfing by working within his metaphor to offer him another way of thinking about the test you want him to take.

Comment #6

I wonder what you made of these comments. These do not seem like life philosophy statements, ride the wave. Rather, they strike me as someone who may perhaps be afraid, and is hiding behind rather flimsy excuses. In addition to a fatalism (which as you correctly note, is sometimes found among Hawaiians), he may also be frightened by what the liver biopsy may show. This is a patient who "looks healthy and fit," and may pride himself on his health. "Potential liver cirrhosis" might threaten his self-image and imply lifestyle changes he doesn't want to make. So these statements also could be beneficially examined for their "deeper meaning."

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Comment #1

An opportunity to exercise curiosity. WHY does this gentleman deny the seriousness of his problem. Maybe, as Dr. Khwaja suggested, he is too terrified of the implications to face what's going on. Everything flows from this - hospitalization, IV antibiotics acknowledge seriousness, therefore the patient will resist this approach because it will puncture his denial.

Comment #2

Sometimes the "scared straight" approach works - sometimes it is too overwhelming. If the patient can't accept the threat of his condition to his bodily integrity, then hearing the details of impending horror will likely simply provoke further resistance.

Comment #3

Another opportunity for curiosity. He may lose his toe, his foot, he may go into septic shock, he may DIE - and he's "too busy"? What could be so important? My guess is that this is simply a defense mechanism; and that the underlying issue has to do with inability to accept the situation. When this kind of reaction occurs (and if you think about it, it's really very understandable and normal!), it sometimes helps to empathize with the scary, overwhelming nature of the situation, rather than trying to "scare" the patient into cooperating. When people are in the grip of strong emotions (such as fear), logical analysis of the situation is rarely effective until you've helped to calm their affect.

Comment #4

Oh dear, I am so sorry this was the outcome. It must have been a terrible, helpless feeling for you and the attending to see the patient leave when his wellbeing, indeed possibly his survival, were in

such jeopardy. As we discussed, such an outcome is never entirely avoidable. All you can do is have as many options as possible at your disposal to try to persuade the patient to act in his own self-interest; and not give up when one approach doesn't work.

Comment #5

When you think about it, who wouldn't want to believe this? The alternative is so frightening and threatening. Especially if indeed Keflex had helped in the past, it would be a challenge to pry him away from the conviction it could work again. Again, a place to start is to validate rather than confront his thinking - "I can understand why you'd think this." Then the patient feels heard and understood; and you can go on to explaining why this is a different and more serious situation.

Comment #6

Again, it might be worth considering whether in fact this is ignorance (for which the solution is information) and lack of concern (for which the solution is motivation, often through fear). Or whether the patient's reaction stems from panic and despair (for which the best hope is listening, recognition, and the reassurance that things can get better).

Comment #7

Again, be sensitive to the implications of language. When we say someone is "oblivious," it implies the patient is unaware even clueless about his condition. In fact, the patient's fear may be "blocking" his ability to process the information he received - extensively! - from you and his doctor.

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Comment #1

He sounds very difficult. It is interesting how sometimes in a couple, one person carries all the demandingness and anger, which in a way allows the other person to be sweetness and light. I wonder how this husband views himself? I wonder if he sees himself as fighting for his wife?

Comment #2

Again, I'm curious about the husband's perspective. Is he genuinely motivated to reduce his wife's suffering? Is he exhausted by her care and looking for respite? Does he feel no one cares, or no one takes their situation seriously? So many puzzling questions.

Comment #3

What a grueling experience! The husband was clearly out of control, no wonder no one wanted to interact with him. Yet sometimes there are ways of interacting with even very angry individuals to

defuse the situation. On the other hand, sometimes forceful action, such as the one you took, is needed.

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Comment #1

Good acknowledgment of her distress. And you can let her know you hear her even more specifically by saying you hear she does not want to go back to Dr. J, as this seems to be the source of her distress.

Comment #2

Good awareness of your own emotional reaction. You want to be careful that these feelings do not inadvertently express themselves toward the pt.

Comment #3

These are really skillful sentences. You convey that this is a difficult dilemma but you are all on the same side. I think a lot of times patients' anger stems from their feeling so helpless in the bureaucracy of the healthcare system.

Comment #4

So well-handled. Each step here is exactly what was needed. Just because she is poor does not mean she should have no choices, or must accept what she considered to be sub-optimal care.

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Comment #1

So the son didn't appreciate the perspective of the physician – and especially didn't appreciate where you, as a medical student, were coming from in terms of your commitment to patients (and the sacrifices you've made to study medicine).

Comment #2

I hope in class we can discuss where you can go from here – how can you improve the interaction? How can you "move closer" to this individual – and do you even want to? What are your goals, and what are the best approaches for accomplishing them?

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Comment #1

As we discussed, the stigma attached to mental illness in many cultures (including still to some degree our own) may inhibit accurate diagnosis and treatment.

Comment #2

Due to your shared language and cultural background, you were able to add epth and nuance to the diagnostic process.

Comment #3

Very valid conclusion. I admire that you were able to express your opinion to your attending; and that's/he was open to listening to your valuable input.

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Comment #1

As we discussed, the issue that organizes a possible culture clash is autonomy: In this country, we perceive all individuals as equal and autonomous. In a patriarchal culture, some women may, out of their own free will, agreed to give their autonomy to their spouse. As we discussed in class, determining whether such a choice is truly volitional or is in some way coerced is extremely difficult, but key.

Comment #2

This comment shows sensitivity to the possibility that the patient had not "bestowed" her autonomy on her husband, and had not deputized him to speak for her.

Comment #3

As we discussed, a good technique for separating patients and family members when you think the former has something important to say that they are reluctant to share in the presence of their spouse or adult child.

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Comment #1

And sometimes, when patients are confused or skeptical about the quality of care they are receiving it can be helpful to mirror back their actual words by saying "A resident is a real doctor…"

Comment #2

Haha,the patient does sound a bit aggressive – although almost certainly since she has a lump in her breast very anxious too. I wonder whether her hostility is not simply a way of managing her fear.

Comment #3

Clearly this was your intent. And you do not state your exact language, so the pt might well have misinterpreted your language. But this is certainly an example that words matter. To the hyper-sensitive patient looking for issues, asking “Do you think getting a mammogram is a good idea?” might add to her sense of being out of control. It is obviously not the same as asking a customer, do you want your burger medium? You do want to sound in charge “We’re writing an order for a mammogram to check out this lump” but also include the patient: “How does that sound to you?”

Comment #4

Great self-awareness. Your thinking about the patient was quite reasonable, given her past history. Forming hypotheses about patients – both medically and psychosocially – is part of being a proactively engaged physician. But you always want to be sure to investigate these hypotheses with the patient. Think about what you might have asked her to assess her attitude toward her presenting problem.

Comment #5

Excellent, you are identifying all the factors that mitigated against you’re checking in with the patient. And I think you might be a little hard on both yourself and the resident – your humanity was there, just at the end of a long list of essential to dos with little time to do them. But as you go on to say, even in urgent care, there is enough time for a quick check in to see how your patient is coping. If you can get her to confess how scared she is, it might help the rest of the interview go much more smoothly.

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Comment #1

There is a lot of misinformation out there that unfortunately can be quite persuasive, especially when it says things patients want to hear.

Comment #2

Yes, of course she does, but I think what troubled you is that she was making decisions on erroneous and misleading information.

Comment #3

It looks like you agreed on a middle path – agreeing to let her use a remedy she probably was already going to use anyway, in combination with careful monitoring

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Comment #1

Sometimes, in these situations, it is wise to ascertain the patient's preferences. Of course, you do not want to ASSUME the pt expects a female dr, even if she is wearing a head scarf, but it is easy to clarify – "Are you Muslim? Sometimes female Muslim pts prefer a female physician. Is this your preference?"

Comment #2

Interesting they did not say this when you walked in the door. It can be hard for pts to assert their requests in such a situation. They may have felt that the clinic had heard but ignored their desire for a female dr.

Comment #3

These are wonderful questions to ask, Robert. I think if you were going to be this pt's continuity care physician (assuming she didn't object to a male dr), they would have been important to bring up at some point.

Comment #4

This is a hard legacy for all concerned. Thank you very much for sharing it with us. I cannot pretend to understand what this experience was like for you, but I'm sure you are correct that it will add an additional dimension of complexity (and perhaps shared bonds) with certain patients.

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Comment #1

Exactly. We have no framework to judge the "reasonableness" of this request. To us, in this country, pt preferences based on fixed categories (e.g., gender, race, age) can make us uncomfortable, and strike us as unreasonable, especially if they might endanger the patient's (or a fetus') health.

Comment #2

Good point – it highlights the tensions that can arise between the patient's care and the student's education. Sometimes these are not always entirely resolvable.

Comment #3

Do you mean that even when you are informed about the reasons behind such refusals, they do not make sense to you?

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Comment #1

I am sure this is an accurate depiction of what transpired. However, it is so important to listen to the questions behind pt questions, and try to elicit them if at all possible. Once "senior doctors" are brought in, once the word "tumor" is introduced, once "more tests are needed," it is worth wondering whether the pt is terrified, despite a calm demeanor. In such a situation, taking great care to clarify what is most likely, and why precautions are being taken, as you go on to state below.

Comment #2

Exactly the right conclusion, Ruth. The pt may not even be able to formulate her questions, but expect that they are there. Rather than breathe a sigh of relief when the pt says, "No questions," as some doctors do, you can help the pt verbalize her fears and misconceptions. "I know we mentioned a tumor – are you worried this might be cancer?" Then you can clarify the likelihood and level of concern, and have the pt repeat it back to you, as it will be competing in her brain with the fear that she has a deadly disease.

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Comment #1

Excellent idea, Ryan. It's easy to have a general sense that "things aren't going well," but it can be harder to figure out where the problem lies. Here you identify several possible sources of difficulty, such as language difference, mother's presence, and mother's angry emotions

Comment #2

I especially liked this "category." Often, when there is tension in the exam room, it is easy for this feeling to "override" all other observations. Here you are able to recognize the "interesting" aspects of the encounter.

Comment #3

As per my earlier comment, it's great that you identified potential resources and positive aspects of the situation. It is usually possible to find these, and build on them in the interaction, but sometimes in a challenging situation, they are ignored.

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Comment #1

Yes, this is an unfortunate situation which shows the importance of good communication among specialists and primary care physicians. Why did the patient not return to the physician who ordered this test? Why did that physician not communicate her concerns to the pcp? Now the patient is alerted to having an abnormal test value, with no one seeming to know what is going on – a very distressing state of affairs, especially for someone with many chronic conditions.

Comment #2

Wow. This should never be a throw-away remark. What an upsetting seed to plant unless it has indeed been substantiated.

Comment #3

Exactly. Words matter, PARTICULARLY in medicine, when there is often so much at stake.

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Comment #1

That's great.. It says you and your various teams are doing a lot right. Also, just as a point of clarification, I tend to think of these not so much as difficult PATIENTS but as difficult ENCOUNTERS – maybe a small distinction, but shifts the onus of "blame" away from the patient.

Comment #2

Hmm. Maybe you should teach this session? Your insights truly encapsulate exactly what we are trying to point out! You are quite correct that, in response to these very understandable human responses to illness and intervention, physicians often have a hard time understanding the patient perspective and do become personally affronted. The result is writing the patient off – not medically, but emotionally and humanly, which often leads to poorer care.

Comment #3

If I could nuance your argument further, I would say that in addition to respect, which is crucial, physicians must also attempt to understand their patients' choices. Sometimes patients make

choices because they are afraid, or angry, or helpless, and are trying to exert some measure of control over an out of control situation. Not every patient choice should automatically be honored. All choices should be respected and explored to ensure that the patient is truly choosing what he or she wants. This is a complex and subtle process, and if the physician is irritated or judgmental it will surely go astray.

Comment #4

You've outlined an excellent model for dealing with "difficult" interactions. I would only stress that the MANNER in which this model is followed – with respect, with sincere interest in the patient/family member's thoughts AND FEELINGS – is key to its success. Winning the patient's trust is a critical component in decision-making. Without trust, patients feel they have to guide their own healthcare.

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Comment #1

True, we cannot always personally relate to the social circumstances of others. I think what is most important is that we are respectfully interested in what they are going through, are willing to listen to their stories, and think actively about how their lives intersect with the medical conditions we are trying to address.

Comment #2

That is quite true. You will not be able to "fix" any of these problems. What you can do is listen humbly and respectfully to how she manages a very difficult and overwhelming life. You'd be surprised how much this can help.

Comment #3

That's a creative thought. Sometimes asking the patient herself what she might do given everything else she's dealing with can also involve her a bit more, rather than your making suggestions.

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Comment #1

This is tragic – and humbling too. It reminds us that there are not always perfect fixes in this life. Sometimes it is very hard to undo the pain of such loss.

Comment #2

And perhaps through this sharing, you gave her a measure of hope as well. As you well know, personal disclosure is always tricky, but given the right context, it can be a powerful therapeutic intervention with a patient.

Comment #3

that in my view shows great awareness and understanding. As you saw, patients' experiences, for many reasons, can scare us. Our natural impulse is to withdraw, get some distance. We blame the patient – "She got meds and counseling, we did everything we could. It's her problem that she's not better." This leaves the patient alone and abandoned with her suffering. Another option is to risk drawing closer to the patient, feel compassion for her suffering, and let her know her doctor hasn't given up on her. This was the choice you made, and I find it extremely admirable.

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Comment #1

Interesting, so you are likely dealing with at least two "cultural" orientations: African-American and JW. Your essay focuses on the latter; but I wonder whether this patient was African-American might have affected the interactions with his doctors in any way?

Comment #2

You state the potential dilemma very well. I wonder what you would have done. On the one hand, you do not want to tell your patient how to practice his religion (and with JW there does seem to be a range of how strictly practitioners follow the no blood products rule). On the other hand, you do not want to inadvertently have created a misunderstanding in the patient's mind so that, upon acquiring further information, Mr. B might conclude his soul would burn in hell for all eternity.

There is certainly no right answer here, but I might be inclined to err on the side of clarity. The JW community tends to be very involved with its members, so I suspect there might be discussion about plasma with Mr. B, either before (or after!) the procedure. Therefore, I'd want the patient to have a pristine understanding of what was involved.

You mentioned that Mr. B's children visited frequently. I wonder if they are also JW. Another approach would have been to bring them into the plasma discussion.

Perhaps these additional steps were unnecessary, and certainly they would have taken more time. It is important to recognize that the healthcare system always exerts pressures in the direction of efficiency and speed, so we have to take this into consideration in making these decisions.

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Comment #1

I can certainly understand how frustrating this must have been to you and the team . You knew what was in the best interests of the patient, but could not persuade the family of this, largely due to cultural considerations.

Comment #2

This is the key learning to take away from this difficult situation from my perspective. Understand WHY they are fearful and WHAT makes them so afraid. Show that you do not judge those fears, but in fact empathize with them. Problem-solve with the case manager or social worker how these concerns can be addressed. Provide reassurance and a different perspective when appropriate. When family members feel truly heard and respected – and perhaps in this case, validated as good children – it may be more likely to find a resolution acceptable to everyone. Not always, but sometimes!

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Comment #1

Wow, you do an impressive job of thinking through this issue from so many angles. You are sympathetic, empathetic, then question these responses, then recognize the judgment in the term “no show,” then empathize again, but this time with the physician. All these dimensions are present, but it takes a nuanced sensibility to acknowledge them all.

Comment #2

This could very well be. If so, it becomes interesting to ask, what is the purpose of this show? What is she trying to achieve? Where does the need for such a show originate?

Comment #3

Again, a balanced and nuanced analysis. You are absolutely correct, it is frustrating to encounter patients who have no organic basis for pain and who sometimes seem to be scamming the system.

And you are also right, their suffering is real, although it might not be the kind of suffering a physician can easily repair.

Comment #4

I agree with you that this physician seems very skillful. Rather than pushing back as the patient ups the ante, he steps back and de-escalates.

Comment #5

And this speaks to your earlier observation that the patient was putting on a show. Her need for the “performance” of her suffering diminishes when she is reassured that the doctor hears her and sees her and takes her seriously.

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Comment #1

Yes, more of the same only "louder," and with an inflection of frustration! In fact, this presentation - as well as the doctor's feelings of frustration - should be a cue to attempt a different approach.

Comment #2

So impressive, especially when this conversation was mediated by the infamous "blue phone," and all the language and cultural differences it entails.

Comment #3

I would amend your statement by adding, "this didn't lead to a diagnosis THIS TIME..." and would argue that, by deepening your understanding of your patient's life, you are more like eventually to figure out the underlying problem (which, as you intimate above, may involve somatization disorder, or another psychiatric diagnosis or simply existential suffering!)

Comment #4

As you know, little in clinical medicine is completely controllable. But I agree that the approach you describe so skillfully above gives you the best chance of keeping your patient engaged and hopeful about pursuing health care.

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Comment #1

Yes, so already there may be some frustration because the patient made a decision that potentially compromised her life. I think the key word here is “potentially.” Cancer treatment is very often not a

guarantee, so it is hard to know what would have happened had she undergone chemo. Would she have been in this same situation? Possibly not, but we don't know for sure.

Comment #2

She sounds as though she has a beneficent and gentle health system in place for herself. Unfortunately, it is also true that none of these CAM approaches has been proven to be able to vanquish cancer.

Comment #3

Chemo is a kind of poison. However, it clearly has a critical role in the treatment of cancer. Linda is inhabiting a world where every message she's receiving is resistant to chemotherapy. I wonder if it might make sense to her to consider chemo while pursuing alternative therapies to counteract the chemo side effects.

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Comment #1

I will have to look at the assignment again, because it is supposed to say a "difficult physician-patient interaction." Once we start labeling patients as difficult, in some ways we have already started down a problematic path.

Comment #2

Another outstanding observation. Indeed, it is often the interaction between the patient and the physician that leads to "difficulties." It is a problem when the physician is not at her best (i.e., tired, out of sorts). And almost by definition, patients are usually not at their best when they are sick and scared.

Comment #3

You managed your feelings of being disheartened, did not give up, and as a result the patient and family started to trust you and "opened up."

Comment #4

Excellent. You do not want to exclude the wife, but you want to do your utmost to include the patient.

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Comment #1

What a good example of a patient with radically different health beliefs and expectations who is nevertheless seeking care within a western context.

Comment #2

I guess the misunderstanding was that the patient misinterpreted her drug reaction as something more serious. But it also seems as though it was a case of overtreatment, or at least inadequately monitored or explained treatment. For example, the patient might have been advised not to take the second medication until she learned the results of the bacterial culture; and/or warned about potential side effects, including rash

Comment #3

You did an excellent job of learning a lot of background about this patient. By situating the patient in her life, you were able to comprehend some of the cultural and familial factors that might have contributed to the patient's fear.

Comment #4

It sounds as though in addition to her concern about how a pre-existing condition might affect her insurance status in the future, she also saw another diagnosis as leading to more medications that might be dangerous, and perhaps about which she was suspicious. It might take some time to persuade the patient that, should she in fact turn out to be diabetic, taking a regular medication would be in her best interest. It would be hard, it would require trust on her part and patience on your part, but it would not be impossible.

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Comment #1

This implies that there is a disconnect between the patient's cognitive understanding and his behavior. This is valuable information.

Comment #2

Excellent question. Put another way, you are asking, how does the physician work with the patient to get buy-in to his own healthcare? One approach might be motivational interviewing, which we'll discuss in class.

Comment #3

Another good question. I'd say your approach was not "poor," but IN THIS CASE it was ineffective. In another case, it might have the desired outcome. But when your approach fails, you want to have

other options. It is rarely the case that patients truly “do not care” about becoming seriously ill. It is more likely that they have not yet figured out a way to respond to this threat because they are too scared, too overwhelmed, or simply hope there is another easier way. That is the role of the of the physician to help them figure this out.

Comment #4

A third superb question. I’d suggest that “hiding your emotions” is not the goal so much as first “identifying” your emotions (as you go on to do, i.e., “very frustrated”), then working with them in a way that benefits the patient. For example, perhaps you can share your frustration within a context of concern and care. Alternatively, you might be able to soften your frustration by becoming more curious about the patient’s perspective and seeking to understand him better. Why is it that he continues to drink soda when he knows it is bad for him? Why does he seem ready to risk his eyesight rather than change his lifestyle? In learning more about his story, you may notice other feelings of caring and compassion that “balance” your understandable frustration.

Comment #5

This is certainly a good coping strategy. The patient’s response very likely has little to do with you (or other members of the team) and more to do with his life history, circumstances, and personality. Of course you can only do the best you can; but by minimize feelings of annoyance and resentment, you will be able to continue to think creatively and with enthusiasm about the dilemma the patient has posed to you. There are no guarantees in clinical medicine. You may not be able to turn around this situation – but by not prioritizing your own frustration, you have a better chance of not mentally “checking out” on your patient ☺.

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Comment #1

The discovery of difference can be scary and offputting. Often we feel most comfortable with people with whom we have the most in common. It is an important skill to develop to learn to be comfortable with those who are different. Sometimes this involves finding common ground, but sometimes it is simply about learning to appreciate, and not fear, difference.

Comment #2

A excellent insight. Especially in in a situation involving pain and illness, or worry about health, fear is very often at the root of expressions of frustration and anger. If I am worried about my health, I want to make sure that my doctor understands me and I understand my doctor. This is difficult enough when both parties are speaking the same language! When language and cultural differences are thrown into the mix, the patient's anxiety becomes very understandable. Of course it is wrong to blame you for not speaking fluent Spanish, but once the patient's fears are addressed, and she is reassured that her quality of care will not be compromised, she will likely let go of this attitude.

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Comment #1

It is definitely a communication complication to work through an interpreter. A good interpreter can create a pretty seamless interaction; but unfortunately our MAs do not have formal training as interpreters; some are excellent, and some less so.

Comment #2

This is a very true statement. However, it will always be the case that sometimes physicians will not be able to communicate directly with their patients. I wonder what your thoughts are about ways that this communication barrier can be reduced.

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Comment #1

How did you feel about this approach? Did it make sense to you? Did you think it was an appropriate way to handle this situation? What would you have done?

Comment #2

So it's the broken record phenomenon. When you encounter this, it is a good cue to try something different, rather than simply repeating the same useless pattern.

Comment #3

For the doctor, the culpability lies with the patient – he is not compliant with medical advice. For the patient, the blame lies with the physicians not helping him. Do you see any way for these two perceptions to be reconciled?

Comment #4

There is no doubt that this kind of interaction repeated over and over can be very frustrating. What else might you feel in this situation? Might you feel curious about why things have gotten stuck in this pattern and how they might be shifted?

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Comment #1