Comment #1

Really enjoyed this introduction. It was funny, clever, and also captures the idealism – and occasional hubris – of the medical student!

Comment #2

Lovely observation – there is much learning to be had in both the doing and the not doing.

Comment #3

This captures very well just how much the physician and medical team can "do" even when there is "nothing" left to do

Comment #4

Very well said, Ahmad. In every situation, you are always a doctor, you are always a healer – or at least you have the potential to be.

Comment #1

Unfortunately, this is often the case. The patient's "readiness to change" shifts dramatically when they have a brush with death. Ideally, physicians can help patients understand the risks at an earlier point, but this is often more challenging.

Comment #2

This was a GREAT question, Alex! I'm so impressed you asked this of your patient. It acknowledged his expertise based on his life experience, and might have generated some valuable insights.

Comment #3

Okay, and this is an honest place to start. For sure, there is no magic bullet. There is no approach guaranteed to "wake up" a resistant or recalcitrant patient. But it is a question well worth pondering – and well worth addressing – over and over – with patients, not in a hectoring or blaming way, but as one of the most important things you can do. Motivational interviewing rather than telling is an effective approach to get the patient to reflect on what matters to them in life and helps engage them more proactively in their own healthcare.

Comment #1

Amanda, this is the correct approach in an interpreted interview, but unfortunately you are also correct that it often means obtaining a less than complete story from the patient.

Comment #2

Yes, you may have had the experience of trying to take a history, and getting certain information; then having an attending who shares a cultural background, language, and continuity relationship with the patient coming in and eliciting a much richer and often completely different story.

Comment #3

I hope we can talk about ways in class to minimize the barriers imposed by language differences.

Comment #1

Wow. I'm in awe of this patient who is so vulnerable, yet so strong and self-aware and insightful.

Comment #2

Also a very impressive doc. Rather than ignoring her patient's emotions, she heard her fear and acknowledged it. Often nonverbal communication is more powerful than words in responding to such situations.

Comment #3

This kind of connection is the foundation of the patient-doctor relationship and is necessary for trust and commitment to develop on both sides. Far from being unprofessional, in my view establishing this connection is the essence of professionalism.

Comment #1

I've often heard this disparity described: i.e., family think communication is purposeful while the medical team does not. It is very hard to say what is "the real." Is the family deluding itself? Do they perceive subtleties the physicians do not? The healthcare team wants the family to be "realistic" and not have "false hope" but what does this really mean? Perhaps they sense something more "objective" people do not. Perhaps this sense of connection, illusory or not, is what allows them to care for this shadow of their loved one day in and day out.

Comment #2

Yes, this is the key question. What are the consequences of this belief/hope? If the grandmother's health is suffering because of it, if other children in the family are being neglected because of it, if the family is spending money it doesn't have on quack remedies, then hope is harmful and needs to be challenged. But otherwise perhaps it can rest in the realm of not-knowing for certain what the true is. In my experience, parents often "know" and "choose not to know" about the condition of their child. To them, hope is a moral position; and to abandon hope in favor of the stark medical realities is to abandon their child.

Comment #1

This sounds appropriate, given the patient's state of arousal. However, when a pt visit comes to such an unfortunate conclusion, you want to leave pt and family with a plan – how to go forward despite

this encounter. You also want to set appropriate limits on the patient – if you feel he has enough cognitive function to understand them – while not blaming or punishing him for his disease.

Comment #2
you summarize the challenges of this encounter very well. Accepting a diagnosis of AD can be devastating. I'm not surprised that the patient resisted this. Also, of course, his verbal abusive may have been a result of or exacerbated by his dementia. I can understand why the physician did not feel able to productively continue the interview. On the other hand, I feel for the daughter who has to go home and cope with the patient on her own; and for the patient himself, who has been dismissed as "too difficult" to care for. I wonder if a referral to the UCI Senior Health Center could do some good. Certainly trying to support the daughter in this difficult situation is appropriate. She might benefit from attending an AD caregiver support group, where she could learn skills to help her manage her father's anger and agitation.

Comment #1

Perfect example – I encourage students not to think of "difficult" patients, which situates the problem in the patient; but in the encounter, which has become difficult often precisely for the reasons you describe.

Comment #2

These are huge problems and although they intersect with medicine, they have their roots in social circumstances that physicians unfortunately cannot entirely address.

Comment #3
I agree this is such a frustrating realization. You can prescribe a drug so that the patient feels calmer when he is shot! In truth, there is little you can do other than help the patient brainstorm his options – could he leave the area? Are there any ways he could improve his physical safety? Perhaps the most important thing you can give him is a sense of respecting his dilemma, not minimizing his fears, and helping him think through any steps he himself can take to ensure his own safety. Not much of a solution!

Comment #1

Seeing a pt who is intoxicated poses several challenges. Ideally, this should be the focus of the encounter. It will be hard to consent a pt under the influence; also, given his level of anxiety, he might arrive intoxicated for the procedure itself.

Comment #2

The resident made a good start, but I wonder if it was enough. It sounds as though the patient may need help in addressing his alcohol dependence.

Comment #3

Something like this might have contributed to the patient's distress. Underneath his anger he seems excessively frightened – of a catheter? Of a rectal probe? I might wonder if possibly there was a history of sexual abuse? Is it the alcohol that is making him behave in this manner? Perhaps he is so afraid of having cancer he is making any excuse to avoid the diagnostic procedure. In any case, before attempting to proceed with the biopsy, it would be important to find answers to these questions.

Comment #1

Ah, this is the key. What has the family doc done to "help" (vs. enable or punish)? Has every stone been turned up? If so, "firing" the patient is an option – but it should be the last option, because odds are this patient will not do well in another practice.

Comment #2

It might be helpful to consider WHY the physician has become a drug dispenser? Was it the easiest course of action? Did it just sort of "happen" without either the patient's or the physician's awareness?

Comment #1

I wonder if this had come up in the initial discussion of J's acne. Was this recommendation easily accepted or was it seen as an interference with cultural practices? Knowing this, how might you approach a similar situation with another African-American patient.

Comment #2

Yes, this small exchange shows why assumptions are often wrong and can do harm to the dr/pt relationship

Comment #3

Yes, in some ways you knew him well, but in other respects you had no sense of who he was embedded in a family and culture.

Comment #1

I am glad she was able to share her fear and sense of being overwhelmed so clearly with you. A lot of patients feel this way, but often doctors treat a diagnosis of diabetes as a rather routine event.

Comment #2

Well-stated – and fortunately, because you and your attending paid attention to the “problem beneath the problem” you were able to meet an agenda she may not consciously have even recognized she had.

Comment #1

When you feel your time is being wasted, it makes less sense to keep trying, doesn’t it? This is a great example of how the “interpersonal” side of medicine can affect physician behavior – in this case, it led to your avoiding your patient’s room.

Comment #2

You know, I don’t think I understand the source of her anger. As you speculate, she may just have been a “not-nice” person. What else might have caused her to behave in this manner? Was she frightened that the doctors could not help her? Did she fear facing her own mortality? Was anger and aggression her shield? What was this woman’s life like up to this point? What mattered to her?

Comment #3

So, despite your best efforts, it was pretty hard to put yourself in her shoes. You couldn’t imagine behaving so badly.

Comment #1

Absolutely - yet individuals are inextricably embedded in families, cultures, societies. These all play a role in what appears to be one person's weight.

Comment #2

Again, very nice turn of phrase. I wonder what you think some of those "underlying issues" are? How do culture, race, history, food deserts, power converge on that XL t-shirt?

Comment #3

Again, well-said. In such situations, before advising must come understanding. Building bridges between worlds is the only way to work together. At the deepest level, you and mom are in accord: you both want a happy healthy life for Elijah. How to get there is going to be a process.

Comment #1

Very well stated – and the truth may be both. However tempting, it is important in medicine to avoid the „boxes“ as they may inappropriately constrain our understanding of others.

Comment #2

It is frustrating for doctors – as well as of course patients – when they can't provide anwers. Under these circumstances, it is easy to put the problem back on the patient by dismissing her as „crazy" or drugseeking.

Comment #2

I might disagree to some extent. Evenif she is a little crazy, even if she is seeking drugs, perhaps her problems still need to be addressed.

Comment #3

Exactly. Determining that a patient is drug-seeking to ease their suffering is important because it will guide decisions about narcotics prescription; but it should not detract from the humanity of the patient or their need for help with their problems.

Comment #1

I think this was "paternalistic" in the sense that you were "telling" her what she should do. But given the previous statement about her feelings, perhaps you were also reflecting back to her things that she felt and worried about.

Comment #2

I'm impressed with this encounter. It feels like you connected with your patient and made it possible for her to see a path forward.

Comment #3

I appreciate your avoidance of cultural stereotyping. It is worthwhile to understand something about others' cultural background, but as you say, it is always important to understand how a particular individual interacts with that culture.

Comment #1

Hmm. The resident's judgmental attitude is inappropriate I feel, although it is easy to see that it emerges from his own helplessness. I like your use of the word "despair" in describing the resident. It shows that it is because he feels so badly that he copes by being critical. I wonder whether this best the best choice for the resident to simply leave the room. Although a great opportunity for you to practice your counseling skills, I worry that the patient might have felt abandoned by her doctor.

Comment #2

Excellent speculation on your part – perhaps the patient's "apathy" was really depression. You are actively thinking about your patient, which the resident perhaps was not dong. You are also actively empathizing with her, which seems to be missing on the resident's part as well.

Comment #3
Absolutely. I appreciate that you have empathy for both parties. The resident is no doubt stressed, overwhelmed, and does not have the resources to cope with a patient who is not behaving responsibly (in his view). Being a resident is very challenging – yet somehow the resident must be able to prioritize good pt care.

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Comment #4
There were many other paths to take. While the resident's exasperation is understandable, that should not have been a justification to end the session without helping his patient to resolve her difficulties – whether emotional, attitudinal, or insurance.

Comment #1
I'm impressed that she opened up so much after the rocky beginning. You must have conveyed a lot of empathy through your nonverbal communication. Most people REALLY want someone to listen to their story. Simply indicating willingness and a desire to learn overcomes a lot of patients' reluctance and fears.

Comment #2

How lovely. This truly evolved into an empathic and meaningful encounter – even with limited Spanish!

Comment #1

What else might you have done about this phone call at this point? As you say, if it were an urgent phone call, it would make sense she had to deal with it. But if not… How could you address the problem directly?

Comment #2

I think you were amazingly flexible, and perhaps too much so. The patient's life and priorities are important and should be respected, but so should the doctor's time. Although you are a medical student, you also deserve this respect.

Comment #3

Again, what are your choices at this point? Of course, you can simply explain to her their importance. But at some point it might be worth asking what's going on. Is she upset at seeing a medical student? If so, that issue can be addressed. But it's hard to know how to proceed if you don't understand the problem.

Comment #4

True, and this is an admirable effort at perspective-taking. However, just because she felt it was "the right thing to do" does not make it right. The mom seemed insufficiently sensitive to YOUR perspective. Therefore, a friendly negotiation regarding the encounter might have been appropriate.

Comment #5

Nicely said. Again, I think the skill is being willing to explore the problem directly. Why is this woman on the phone? Is she telling her babysitter she's stuck at the doctor's? Is she changing a salon appointment? Be willing to nonjudgmentally find out what's going on, and then you will have a better sense of what to do about it.

Comment #1

Agree, our healthcare system is not set up for smooth communication transitions. The patients are often baffled and the doctors frustrated. It is especially important to check comprehension, for example using the teach-back method

Comment #2

All these examples of you, as the medical student, having to remedy miscommunications or lack of communication that has occurred upstream.

Comment #3

Very interesting – the doctor is an authority figure who can't be bothered with questions. Thank goodness you appeared sufficiently approachable to address patients' confusion and concerns.

Comment #4

So good to hear this! The best solution to these problems is training more Latino and Latina physicians and physicians who are culturally sensitive and linguistically competent.

Comment #1

He does sound very dedicated. Just remember that the quality of dedication can look very different in different doctors, and still be genuine.

Comment #2

Exactly. When dedication to one patient makes other patients wait 2-4 hours, this demands a certain dedication to the doctor from his patients. This might be a lot to ask.

Comment #3

See I'm not sure I would define this as a dedicated doctor so much as a doctor who needs some help setting priorities and organizing his practice

Comment #4

This is a very good insight. This physician sounds very committed and caring, but he might have trouble delegating. Not only his staff, but perhaps his patients as well, might benefit from being given more autonomy -. If the doctor could develop partnerships with both his office staff and with his patients, then he might not have to manage so much personally.

Comment #1

This is a superb question. The question I'd ask in return is, what kind of reassurance did you want to offer him? About what did you want to reassure him? Perhaps, although no doubt he longed for reassurance, perhaps there was something else he needed as well?

Comment #2

I wonder, as time began to run out, what Mr. A needed to talk about. I wonder if he realized in some way that he was likely dying. I wonder if there was a way to talk with him about this.

Comment #3

Explanation and information can be valuable to a patient. What else might Mr. A have benefitted from talking about?

Comment #1

This is a difficult conversation to have with any parent. It becomes enormously more complicated when the interpreter is the child about to receive these vaccines, no matter how mature she is.

Comment #2

I wonder whether the mother was convinced, or merely acquiesced, intimidated by the American medical system.

Comment #3

I wonder what you think are the implications for various western practices such as vaccinations. Should patients of different cultural backgrounds be exempt from vaccinations? If not, how should discussions such as the one between this mom and attending ideally be approached?

Comment #1

Very happy to hear it. It is true as well that to some degree difficulty is in the eye of the beholder.

Comment #2

Excellent observation – indeed it is a joint undertaking. If that happens naturally, then it is an ideal situation and everything flows smoothly. When that does not occur, is there anything you can do to “bring the patient on board?”

Comment #3

Could this be a place to start? Why was he not “fully present”? Why did he have a flippant attitude? What had caused him to come to the doctor today? Why had he waited until so many problems accumulated? Until you and your patient can establish a shared agenda, as you rightly observe, it will be hard to make much progress.

Comment #4

Indeed it sounds as though you were trying extremely hard. I wonder if you asked the patient about his goals and expectations for this visit; and if so, how you could reconcile them with your own agenda of addressing his many medical problems.

Comment #5

This is a key insight. The patient comes to the doctor, yet he is not “cooperating.” Why not? Why did he bother to come? Until you can make sense of this seemingly illogical situation, you will have trouble proceeding effectively.

Comment #1

This sounds like a longstanding problem. WHY did she not want to take the medications? What was making her so “stubborn”?

Comment #2

It sounds like you made a valiant effort to “get to the bottom” of her resistance. It still seems important to me to understand. Sometimes if you ask an open-ended question – “when you think about medications, what comes into your mind? How do you feel? What experiences have you or your family had with medications? What is someone taking a medication on a chronic basis like?” etc. In other words, try to prod her into revealing the source of her resistance.

Comment #3

Excellent – this shows flexibility on your part. If she is willing to try diet and exercise, and is unsuccessful at lowering her BP, she may be more likely to try the medication. You showed her you were willing to meet her halfway.

Comment #4

Actually, you didn’t fail to encourage her, you were not able (this time) at convincing her. Be careful of the language you use – thinking we failed can make us angry at ourselves, and sometimes angry at the person responsible for our “failure.” I think you made an excellent beginning.

Comment #1

Of course this is a heads up there may be problems. It's both good to have this knowledge and at the same time not immediately begin making assumptions about the patient.

Comment #2

What did happen exactly? You and the resident spent a great deal of time, with no tangible benefit to the patient, and indeed the patient leaving in anger. Do you think the patient was drug-seeking? That might be plausible, especially given the earlier incident. If so, what pain was the patient trying to mask? The pain that emerged on physical exam? Other pain? I wonder what the patient's expectations were. Did she want the physical? Was the physical a "ticket" to the flexeril? If the patient appeared to be seeking medications inappropriately, could this have been addressed directly? In retrospect, what was the main issue in this encounter?

Comment #1

I like this language so much better than "Patient was in denial about her illness." I think your word choice more accurately describes the patient's state.

Comment #2

Yes I agree. Unfortunately it sounds as though there was not enough time to understand why this was so important to the patient. What does this trip mean to her? The medical aspect is important, of course, the risks she is assuming by going, and certainly it will be essential for the patient to consult her cardiologist, but the questions you ask are equally important and deserve answers.

Comment #3

I agree. You will observe skillful clinicians "manipulating" time in order to get the most out of it (and time can be more elastic than the 15 min. designated). Nevertheless, I think you are challenging the structure of primary care encounters, which are established primarily for financial reasons, rather than the benefit of the patient. It is possible – indeed necessary – to envision other models.

Comment #4

Absolutely agree with you. It is in getting to know your patients that your own satisfaction lies. And it is also true that by getting to understand who they are, their values and priorities, you will be able to deliver better healthcare to them.

Comment #1

This does sound worrisome, you and your attending were right to be concerned.

Comment #2

This is exactly the question that needs to be resolved, and there is probably not an easy answer.

Comment #3

You state the ethical dilemma extremely well. I will be interested in your thoughts about how to approach this problem.

Comment #4

Here are some thoughts about how you might proceed:

Step-Wise Model of Intervention in Case of Competency Issues

Do nothing

Engage patient to the extent possible in the dilemma. Although patient has lost some capacity, it is possible he retains sufficient self-awareness to realize that receiving some support would be preferable to losing all autonomy.

Work with patient to simplify self-care tasks if feasible

Identify informal support mechanisms if available – (caregivers at housing facility, family, friends, church etc.)

Explore assisted living facility that offers more support

Court order to provide a legal guardian/decision-maker

Comment #1

With this disclosure, you would also want to make sure that the husband, now that he is dependent on the wife he abused, his safe in his home environment.

Comment #2

This is always our first impulse – do something to make the patient feel better, to take away their suffering. Sometimes it makes most sense just to listen, to let her describe her guilt (and possible her relief, leading to more guilt).

Comment #3

This approach sounds sensitive to the patient's needs and beliefs. Encouraging her to seek a source of both divine forgiveness and social support might well be healing for her. In addition, problem-solving the pragmatic obstacle that has prevented her from reaching out in this way was also critical.

Comment #1

Very honest and interesting self-awareness. When we are in the presence of what we perceive to be disability/difference, we often (unconsciously) interpret that has inadequacy and "condescend" to the individual in the way we interact. I appreciated your sharing this insight in class, since most of us have a similar tendency.

Comment #2

This was the right action on your part. The patient's behavior is inappropriate, and the fact that he is deaf does not mean it should be ignored. My personal view is that the attending might have been able to do a better job of preparing you for this encounter (since this was well-known behavior at the clinic) and also protected you a bit more by setting limits on the patient.

Comment #3

To me, this is already inappropriate behavior. I am puzzled that the attending saw this differently. Maybe there is more back story that neither of us understands. Regardless, it does not seem to me the best choice to have a medical student walk into this situation without warning.

Comment #4

And under most circumstances I would agree with you. But no physician is required to put himself or herself at risk either physically or emotionally. You might have asked the patient to get dressed before continuing the educational session, but honestly, at this point in the encounter, when the attending himself did not take the lead in setting a limit, I do not feel it is the medical student's responsibility.

Comment #1

Very nice recognition that biomedicine is indeed its own culture with its own language, customs, belief system etc.

Comment #2

Lovely insight – even a seemingly straightforward expectation such as “concise, relevant, time-oriented” history may make little sense outside of medicine.

Comment #3

Wonderful awareness, Gabi. These are expectations, not givens. And they are expectations that do not always make much sense to people who become patients.

Comment #4

Another excellent perception. It is easy to blame and judge patients who do not conform to our priorities or ways of being in the world. When doctors adopt this position, it is very hard for them to truly help their patients.

Comment #5

Again, very nicely stated. We see biomedicine as simply “objective reality,” while we view culture as subjective, irrelevant, or an obstacle to be overcome in the care of the patient.

Comment #6

Very well-stated. It can be surprisingly difficult to wean physicians away from the idea that their view is “right” and their patients’ way of understanding their world is “misguided.”

Comment #1

Interesting – and understandable – comment. In the ER setting, it is hard to have any sort of conversation, but in a different setting can you imagine a different approach to work your way into a “goals of care” discussion? It is clear that the frontal assault is not going to be effective? Where else could you start?

Comment #2

If the patient has truly decided that he relinquishes his autonomy to his wife, that is a choice that must be respected. Yet I wonderful whether by talking with him a bit about his life and what is important to him, he couldn’t be engaged in a conversation about his own death.

Comment #3

Heartbreaking last line. It speaks to the inherent limitations of what we can and cannot do for those who come to us seeking aid and succor. In those situations we feel inadequate and helpless so we look away. I wonder what it would mean to the patient if we acknowledged that we saw him.

Comment #1

Haha, although humor can be very culture-specific, so it can be tricky to use in the absence of shared cultural reference points.

Comment #2

Both good hypotheses – it can be as important to think about the nature of the doctor-patient relationship as it is to think about the differential diagnosis.

Comment #3

I'm not sure I entirely agree. Perhaps to nuance your statement a bit further, it may be that some patients want a more formal relationship. Yet in my experience, all patients – at SOME point in their care – want a physician who respects them, thinks about them, and cares about them. How this LOOKS, however, may vary quite a bit.

Comment #4

What I would say is that connection furthers BOTH the patient's and the doctor's agenda. I think we could agree that for effective care to occur, there must be trust. Trust is built in two ways: 1) achieving positive outcomes 2) having a connection. Since positive outcomes cannot always happen right away, the patient must TRUST that you know what you're doing to accept your advice. That trust is grounded in some sort of human connection. I think what you may be struggling with is the fact that a desirable connection may look/feel very different to different people.

Comment #1

Nice way of handling your own lack of knowledge. Never pretend to know more than you do – the best approach is to acknowledge a limitation, while reassuring the pt. that you will find the answer.

Comment #2

It would be interesting to explore the difficulties in quitting. Are they similar to stopping smoking? Would there be a sense of social ostracism because she was no longer participating in a pleasurable activity with her peers?

Comment #1

Excellent insight, Jack. When the physician's agenda is not transparent to the patient, it can create misunderstanding, or even a feeling of being ambushed.

Comment #2

Thank you for this acdknowledgment, so much more honest than saying, "Oh, NOW I understand this gentleman." You don't and neither do I; but understanding that we don't understanding is an important first step.

Comment #3

Beautifully said – a lot of times, when we give people space to reflect, they come up with much

better ways of moving forward with their own lives than we ever could ☺

Comment #1

I wonder if she didn't understand or couldn't afford to understand – if she acknowledges the severity of her condition without having the ability to manage this complex medical regimen, she would only be frightened and depressed, AS WELL AS noncompliant.

Comment #2

Yes, this confirms for me that she does understand, so that is not the problem. What does she need to be more compliant?

Comment #3

I wonder what this meant – was she embarrassed that she would need these aids? Was it galling to admit to her family how ill she is?

Comment #4

Yes, many patients come to the doctor hoping to hear that their problem is "nothing" or that it can be quickly fixed with a simple pill. When they learn it is yet another scary, serious problem, it just adds to their sense of being overwhelmed.

Comment #5

Again, I wonder if she really doesn't understand, or if she resists understanding because of all its frightening implications.

Comment #6

Aha! When a dysfunctional pattern starts to repeat itself, it is time to try something different. What might that be? How might you try taking a different approach with this patient?

Comment #1

Sometimes you can say, “Please help me understand your thinking.” You don’t want mom to feel judged or blamed, but sometimes listening to the parent’s logic can give you ideas about how to present a different way of thinking about the situation.

Comment #2

Yes, you are correct. You cannot compel mom to vaccinate; although when he child is older, the state can forbid her enrollment in public school. Ideally, behavior change can occur through persuasion, rather than legal remedy, but this is not always the case.

Comment #3

Great ethics question! Are vaccinations like seatbelts? Or perhaps more important than seatbelts because they confer protection not only on the individual, but on those around him or her.

Comment#1

I’m impressed by how much you were able to discover about your patient. What a terribly hard life she has had.

Comment #2

I wonder how you feel about this. I wonder how you feel about the quality of Ms. Rojo’s care. What do you think might be a better placement for her than an acute care hospital? How can the medical system truly help her?

Comment #1

Very nice, Jessa. You realize that a “difficult” encounter is at least as much about you as about the patient.

Comment #2

Having been on the parents’ end, I can empathize. It is heartbreaking to see your child’s hopes crushed, even temporarily.

Comment #3

The assumption you’re making here is that people with a high level of formal education will always see eye to eye with the physician. Not necessarily. If the kid’s college scholarship is riding on this knee, well-educated parents may push back just as hard. This is an emotional as well as a logical issue.

comment #4

And I would just add “yet.” They may need to talk to the orthopedic surgeon or get another opinion before they can accept this outcome.

Comment #5

This is too bad, because I suspect with time, and listening to the parents’ disappointment and fear, this could have been resolved.

Comment #6

Yes, patients and families can distrust physicians – with or without previous negative encounters – especially when they are hearing something that will upend their lives. Doctors should not take this personally, it is just part of the process. The parents will look desperately for another option, until they’ve been persuaded it doesn’t exist.

Comment #7

Well said. Being a good doctor does not mean acceding to patient’s/family’s wishes, but compassionately helping them to see the facts on the ground. This doesn’t always go smoothly, but that is just part of the process, and not a cause for alarm. It is when the doctor gets entrenched in a certain perspective and starts to argue with the patient/family that things go awry. It’s always important to give the family’s perspective a respectful hearing, without immediately saying why it doesn’t make sense.

Comment #1

What an interesting comment. It tells you a lot about his expectations and what will NOT be a good approach to take with him!

Comment #2

What an honest statement. Most patients don't dare be this honest with their doctors. What an interesting starting point for a conversation.

Comment #3

Well, you're right, it's clear he doesn't want advice, but what DOES he want? Why is he seeking medical attention at all? It suggest he partly wants help and partly resists it. What is he afraid of? (Maybe dying from his diseases, but also losing all pleasure in his life). There's really a lot here to discuss!

Comment #1

Good close observation on your part; I can see you eager to learn as much as possible from all sources of information about your patient.

Comment #2

This can be a huge problem for geriatric patients, especially those who are extremely ill and feeble. It's wonderful you were making a home visit

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Comment #1

Ah. It shows how important "personal knowledge" of the patient and family can be.

Comment #2

Overwhelming to hear and try to sort out, but how much more overwhelming to live. As a wise physician once told me, whether or not you open Pandora's box, that is where the patient is.

Comment #3

Very well said. In the face of such almost unimaginable challenges, we might do well to choose the term cultural humility, rather than cultural competence, as it is unlikely the health care provider in fact has complete competence in this situation. That being said, the counsel and encouragement of the physician can be a valuable influence.

Comment #1

So there was a tension between the amount of time you had available to this patient; and the amount of information she wanted to explain her health status.

Comment #2

In this case, good strategies that you have learned to redirect and focus the conversation were not effective. Sometimes when this happens, it is worthwhile to think what is the real problem here? (patient has more questions than I have time to answer) – and address it directly (politely and respectfully). It is not the patient's fault that she has many questions; it is not your fault that you only have 20 or 30 minutes to spend. You must both find a way to work within these parameters.

Comment #3

Well put. This is exactly the problem. Your approach was a good one, it just didn't work. In class we'll talk more about other ways to handle this situation. There are no magic bullets, but perhaps the most important thing is not to allow your – or your patient's – frustrations to impair the relationship.

Comment #1

I can understand why he would behave in this way, although his frustration and pain do not justify his being unpleasant.

Comment #2

Whoa. This is a very big, life-altering step, especially for a 23 yo. Is this was Ortho was recommending? He must be suffering greatly to consider such an action.

Comment #3

Empathy is easy to generate for pleasant, likable patients. It is in situations such as this that our empathy is challenged. I'm glad to see that you and the team persisted in attitudes of caring and empathy as otherwise the patient may have made a poor decision out of spite or impetuousness or helplessness.

Comment #4

This makes all the difference. When so much is at stake for the patient, it is important that he has the best chance of making the choice that makes most sense in his life. Creating a space of support and understanding in which he can wrestle in a meaningful way with his options is an important obligation of his care providers.

Comment #1

This is the dilemma. You cannot enable his narcotic addiction, yet without the buffer of drugs, he may truly be a danger to himself.

Comment #2

This in itself is wonderful – that you and the medical team were willing to THINK about the predicament of this patient, and to consider it from a moral perspective.

Comment #3

These are great questions. Sometimes – usually often – such questions do not have neat, simple answers, but asking them is very important because this process can illuminate a way forward. Asking them AS A TEAM is especially important because you will elicit different viewpoints and perspectives that will ensure the answers you eventually settle on will be nuanced and honor the complexity of the situation.

Comment #4

It is certainly not easy to help this patient – but even conveying to the patient that you want to help him, that you take his pain (whether emotional, physical, or both) seriously, is a start. As I'm sure everyone in that room knew, the ED is not the best place to treat such a patient. Ideally he could transition to a continuity primary care relationship where his complicated problems could be sorted out.

Comment #1

Communication issues don't necessarily related in any way to competence, but I'm assuming that the patient was able to make medical decisions for himself?

Comment #2

Was he able to explain why? I can imagine how your understanding of his refusal was severely limited by his communication issues. Was the wife a possible resource? Did you attempt to discuss this both with wife present and wife absent?

Comment #3

Yes, this is the key. Is he depressed by the overall state of his health? Is he afraid of the procedure? Is he embarrassed by his limited speech? Until these questions can be answered, it will remain a dilemma.

Comment #1

Ouch. Inappropriate on so many levels. Both racist AND sexist, not to mention unprofessional. I wonder if it is an older white male in a vulnerable situation attempting to regain control himself.

Comment #2

You perceive very well that this is not simply an "ice-breaker" question, and not simply one that focuses on difference, but also may imply superiority/inferiority, belonging/not belonging, inclusion/exclusion etc. I wonder if you feel the question would have a different "tone" if for example it were asked by an immigrant from Nigeria.

Comment #1

I'd just note that the role of the medical student is NOT to serve as an interpreter. While sometimes this is in the best interest of the patient, it is important that attendings and residents be respectful of students' roles as learners.

Comment #2

I agree this was likely not the attending's intention; but as you note, language is important and intention is easily misconstrued.

Comment #3

What a difficult dilemma. As you know, an interpreter is supposed to translate the exact words of the physician. It is the physician's responsibility to choose appropriate language. But when this does not happen, what should the interpreter do?

Comment #4

It is actually not the MA's role either to serve as interpreter. The non-Spanish speaking attending or resident should either use the (part-time!) official interpreter or the blue phone. It's a very unsatisfactory situation.

Comment #5

Regarding this latter point, since so many patients use CAM as well as standard western medicine , it is essential for physicians to be both knowledgeable and nonjudgmental. CAM is not necessarily benign, so physicians need to appropriately caution patients; but they must do so in a respectful manner that elicits the patient's rationale for using CAM and why they think it is helpful.

Comment #1

This is a very insightful observation. A superficial reading of this situation might conclude that this doctor is a saint for being so dedicated to his patients. However, while he seems dedicated and caring, he is misusing his power as a physician to require these lengthy waits from his patients.

Comment #2

You are parsing this very well. This doctor does some things extremely well, but making patients wait hours (!) – and sometimes into the night, as I have heard from another student – is inappropriate and inconsiderate. It should not be an either-or. It is possible to care about patients, and also see them in a timely fashion. This physician may need help in reorganizing his practice.

Comment #1

This is indeed an unusual response to getting better! I wonder what was the source of his uneasiness.

Comment #2

I admire that you put such effort into making all these arrangements for Mr. D. It sounds as though this was something very important to your patient.

Comment #3

This is excellent self-awareness on your part. Physician emotions rarely effect the quality of the biomedical care they deliver, but they do leak out in ways that affect the doctor-patient relationship; which of course in turn affects aspects of care such as trust, compliance, follow-through, receptivity to treatment recommendations etc.

Comment #4

Actually, I'm not sure whether "benefit of the doubt" was necessarily appropriate. If these symptoms had no clear medical explanation, you were right to be skeptical. However, you are also right that the best response to patients' attempts at "manipulation" is not "personal dissatisfaction," because this is not primarily about you, but about the patient. I can't help thinking that the key to the patient's behavior might lie in understanding his reluctance to be discharged. In this case, honestly but nonjudgmentally sharing your doubts – "Sometimes when we are afraid of something, we become sick so we don't have to face it. Medically, your symptoms don't add up. I'm wondering if they say something about your worries about being discharged" – might lead to a useful discussion that could target the underlying issue.

Comment #1

Loved that you put these words in quotes – this language of medicine is how we attempt to control anomalous situations that make us feel out of control.

Comment #2

Beautifully expressed. You and your patient found authentic common ground, a path you could share, even if only for the moment of this encounter.

Comment #1

Yes, two difficulties: 1) you could not communicate with your patient directly 2) the family member/caretaker did not seem to have much information about the pt's complaint.

Comment #2

You were likely balancing your need for a comprehensive PE with your concern to antagonize or distress your patient. If you could not set the pt at ease, even with the brother's help, I think you made the right call.

Comment #1

I completely agree. Labeling a patient “difficult” tends to place blame on the patient; whereas in fact most difficulties arise because of characteristics of the situation, the patient, and the doctor.

Comment #2

I always find this such a provocative phrase. As you go on to speculate, is it that the patient has never been “educated”? Unlikely. Is it that the patient lacks the intellectual capacity to “understand”> Also unlikely. Is it that acknowledging a serious medical condition leads to all sorts of frightening and not entirely controllable implications and consequences? Perhaps. I hope we can discuss this issue in class, as it is a common perception I hear frequently.

Comment #3

I agree. The blue phone is a necessary aspect of language discordant medical interviews, but it usually does not facilitate connection or trust.

Comment #4

Perhaps it is useful to think of developing the patient’s understanding as a process. Groundwork can be laid in the hospital, but it may take a continuity relationships with a Spanish-speaking pcp to ensure continued progress toward acceptance and engagement. One wonders why this has not happened to date. No pcp? One who doesn’t have time to

Comment #5

Interesting. So the patient was able to generate, to his own satisfaction, a plausible and certainly much less scary explanation. This makes a lot of sense. Let’s discuss in class some different options for how to address such a coniction.

Comment #6

This is an excellent insight. As well, you need skills to help elicit and then overcome patients’ fear, denial, resistance, and alternative explanatory models of their symptoms.

Comment #7

Yes. Patience is indeed a key physician virtue. Learning to manage frustration, to be curious about your patient's resistances, to be empathic to their fears, and to be willing to try again when things don't go well is the clinical definition of patience ☺

Comment #1

This sounds like exactly what happened. The physician is moving way too fast to intervention without acknowledging the patient's agenda; labeling the pt with a pejorative term; and simply reiterating a treatment that was obviously traumatizing for the patient. The doctor is likely trying to help the patient – although this patient may make him feel helpless and he may have judgments about such patients – but his behavior is having the opposite effect.

Comment #2

While there is some merit in the idea of "matching," many patients do not have the luxury of finding a "perfect match" with a physician, especially patients such as the one you describe. I think it is the obligation of the physician to maintain a nonjudgmental attitude and to sincerely attempt to hear the patient and help the patient. .

Comment #3

Hmm. I'd say that part of medical professionalism is to treat every patient with respect and in a way that preserves their dignity. This doctor is not guilty of legal malpractice, but moral practice.

Comment #1

Was this a language concern, a health literacy concern, a cognitive function concern? Each of course might have a somewhat different answer.

Comment #2

Good for you – not ideal, but instead of throwing in the towel, you adapt to the circumstances. This also no doubt conveyed to the patient how important you felt this information to be.

Comment #3

Great question! You diagnosed some problems, you developed a treatment plan, and you embarked on conveying what she needed to do. So yes you did, but not enough. Would a follow-up phone call have been feasible? Perhaps to the staff of the ALF if the patient's comprehension was questionable?

Comment #1

These failures happen far too often, and waste valuable time when doctors could actually be practicing medicine!

Comment #2

It was not at all fair that the patient directed his ire at you and your resident – clearly he needed someone to yell at, and you were available.

Comment #3

To be fair, frustrated patients ALSO spend a lot of time yelling at their insurance company's representatives, but these poorly paid workers usually do not care as much as the patient's doctor. To them it is just a job, and it's hard to realize it's someone's life. The physician often sees this more clearly.

Comment #4

Very well said, Lauren. It is both/and. Patients desperately need an advocate; but you cannot fix all that ails the US healthcare system. Patients are frightened and feel like no one cares. Often they use anger because they feel helpless and powerless. As you rightly point out, it is rarely the doctor who is to blame, yet often the doctor who receives the brunt of this anger. Remembering the patient's fear and lack of control does not excuse bad behavior, but it does help explain it. I agree, the best that can be done is to do what you can to help each individual patient, while also doing what you can to make healthcare in this country more equitable.

Comment #1

Unfortunately, the physician's response escalated the situation, made the patient feel helpless and ignored, and precipitated this angry reply.

Comment #2

That is true, but it is also true that you did absolutely nothing wrong – your gender made the patient feel vulnerable, and you were right to acknowledge this discomfort and leave. If the attending had done a better job of preparing the patient that a female medical student would be present, the patient might have agreed to your staying for the less sensitive parts of the exam.

Comment #3

I think that if this situation had been handled differently, it could have ended up as a rich learning experience for you. For example, if you had had an opportunity to talk to the patient about his feelings of discomfort at having a female present during his physical exam, you could have understood him better. If he had understood the importance of the encounter to your learning, he might have relented, at least for a portion of the PE.

Comment #1

So this patient first demanded special accommodation; then arrived very late; was rude to the medical student; and was not that sick. This sounds like the definition of entitled!

Comment #2

I wonder if you feel there should be any follow-up with this patient. What if anything can be done to reduce the likelihood of such an encounter recurring next time pt is sick?

Comment #3

This was certainly a frustrating encounter. It will be interesting to reflect on how one should respond in a situation like this. I would want to know – is this typical or atypical behavior for this patient? What is it about being mildly ill that causes such panic? Has his physician previously discussed the issue of antibiotic usage? What kind of feedback if any should this patient receive? It is worth considering what makes people behave in this way, so that you can learn to work with their triggers and hopefully have more positive therapeutic interactions.

Comment #1

Yes, this is quite understandable and likely what most people entering that room would have thought. I respect that you were open to seeing someone who was different from what you expected. In terms of motivational interviewing, you were lucky enough to encounter a patient with high readiness to change; and a physician skillful enough to take advantage of this.

Comment #2

This is even more amazing. It is a real tribute to your attending that she was able to set such strong boundaries, yet to do so in a way that the patient accepted and actually gave him hope. As you no doubt know, it doesn't work this easily every time, but from your description you had the opportunity to see an outstanding doctor-patient interaction around opioids and addictive meds.

Comment #3

Excellent observations on your part – it's great to be in awe of the attending's skill, but even better to be able to identify specific ways of interacting she used to accomplish this positive outcome.

Comment #4'

I think this is key. The patient felt he had a partner eager to work with him, rather than an authority who was judging him. Again, another good observation on your part.
