Comment #1

Excellent self-awareness. This "uncomfortableness" is common in clinical medicine; and can filter into the history-taking in ways that reflect bias or judgment.

Comment #2

Unfortunately, it is all too easy in medicine to form judgments or make assumptions about patients in terms of a wide variety of categories (sexuality, race, class, religion, stigmatized illness) that then become part of who they are according to the healthcare system, and can adversely affect the care they receive.

Comment #4

Questions such as "who needs to know" and "how should certain information be presented" are essential in protecting patients from violations of their confidentiality and dignity.

Comment #4

This was an interesting and unexpected essay. I don't think anyone else in the 10 yr history of this session has reflected on the ways in which medical students (and physicians) access information about patients' sexuality.Your thoughts showed both sensitivity and insight. There is first the privilege and attendant responsibility of taking possession of intimate details of a person's private life. There is also the very real possibility that such information can be improperly disseminated or represented because of healthcare providers' own biases, prejudices, and assumptions. I think you are on the right track that awareness is the key to protect patients from violation when they have bestowed their trust.

Comment #1

It sounds like you generally handle this difficult situation very well. Of course, it is very regrettable that this bias should exist in the first place; and even vets should be able to understand that you do not represent all Americans of Middle Eastern background (whatever that means), much less all Middle Easterners. Your commitment is to care for the patient, if possible, while not being subjected to prejudiced remarks or other forms of verbal abuse. It is a hard line to find sometimes.

Comment #2

Ouch. I am not sure whether the patient was just sullen and uncooperative with you, but for me this verbal remark crosses a line. It does not mean you should not continue to care for the patient, but just as with a patient who was verbally or physically abusive in a different context, it is appropriate to set some limits. Rather than letting the remark pass, the attending (better than the medical student) could have confronted it: "I don't know, should you?" Or more Socratically, "You sound alarmed. Help me understand what you're worried about." Or other variations. I have also seen physician take a firmer position, especially in defense of their colleagues. Once on rounds I heard a patient say in

reference to a Vietnamese American resident, "I want an American doctor," and the attending responded, "Dr. X is an American doctor and one of our best. You're lucky to have her."

Comment #3

I would say that this is true sometimes; and it is definitely one option. I think it is reasonable to see if the tension eases and whether, through your actions, you are able to show that you are a good and trustworthy doctor. However, as above, I feel it is also reasonable to challenge such remarks not with hostility but with curiosity and a desire to go deeper both to force people to take ownership of their glib racism/xenophobia etc. and perhaps to show them that in certain spaces, such as an institution of healing, such comments are not acceptable.

Comment #4

Wow. I find this very painful to read and it worries me as well. Is it like the frog in the pan of slowly boiling water? Have we as a society fallen so low that these terrible comments have become the norm and should just be shrugged off, with the hope that they do not lead to worse?

Comment #1

This is a particularly important point. Using the patient's native language when possible conveys that "I'd like to speak with you on your own terms. I do not expect you to be fluent in English" - an important message to make explicit for patients from immigrant communities, who feel increasingly unwanted and ostracized.

Comment #2

As you point out, taking a little extra time with language also allows you to reap many benefits, which in the end may also gain you time. Even if this is not the case, you have taken the time to acknowledge your patient on a human level, and from an ethical perspective, this is worth a great deal.

Comment #3

I respect your commitment to using and improving your Spanish. As you've realized, communicating in the patient's native tongue leads to many positive outcomes in terms of communication, trust, and rapport. The result is a happier (often more grateful!) patient and often a better medical outcome.

Of course, it is always important to recognize the limits of one's language skills, especially in the institutional pressure cooker of productivity and efficiency. Many times I've seen, as I'm sure you have as well, physicians with limited language proficiency take shortcuts and make assumptions or have actual misunderstandings because they try to power through without an interpreter.

So it is a balance. But I completely agree that the more you can converse directly with the patient, the more rewarding and more illuminating the interaction will be.

Comment #1

I agree, the honesty is refreshing. So I'm curious. What was the root of this apathy? Does he simply "not care"? Is he afraid of medication? Does he not want to be "sick" with many chronic conditions? Is something else stressful going on in his life?

Comment #2

Too bad (I suspect you were working with Dr. Nguyen, he is such a creative physician). This can be such an insightful exercise, especially when the physician is feeling "stuck" with the patient.

Comment #3

True, and of course you cannot "create" motivation in someone who is lacking. Sometimes motivational interviewing can help uncover at least seeds of motivation. If motivation is low, especially in primary care, it is the physician's job to simply hang in with the patient, persisting without nagging, in the hopes that one day they will indeed be ready.

Comment #4

it is indeed frustrating when there are so many patients who want to improve their health yet lack the resources to do so; and other patients who have the resources but lack the motivation. Both patients face problems that are difficult to overcome - and their doctors must do their best to help them find the external resources OR the internal resources needed to provide good care. These can both be challenging, sometimes impossible because our society is imperfect and so are we. Sometimes in the case of a patient like the one you describe, it can help to understand the "WHY" of the patient's resistance - it is usually more than indifference or laziness. Sometimes an MI approach can strengthen the patient's resolve to intensify his or her efforts. Just as the physician should never abandon the underresourced patient who have been shut out of care by our inequitable health system, so it is important to stay the course with patients who struggle to adhere to their long-term medical regimens. When we can bring an attitude of curiosity and interest to their noncompliance, we can reduce our own frustration and increase the likelihood of maintaining a productive relationship even in the face of inconsistent motivation

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Comment #1

What a great question! It helps the patient assume an active role in their healthcare,rather than only being a naysayer.

Comment #2

Helping the patient see the big picture, "connect the dots" about their own wellbeing, can be a very helpful contribution to therapeutic change.

Comment #3

Perhaps in addition to the content, the patient begins to feel that the resident actually cares about her, and this too facilitates her engagement.

Comment #4

I agree wholeheartedly - this is indeed a glimpse into the center of what family medicine is all about. Here you see a resident who is able to adapt his/her approach to the needs of the patient - rather than simply telling the patient what to do, the resident asks, what do you need from us? The resident involves the patient and she responds positively. The resident is also able to help the patient understand the "big picture," the WHY of her misery, which may help her toward adherence with recommended medical treatment. Finally, I suspect the patient began to feel because of the resident's "enthusiasm" that this doctor actually cared about her, and she responds in kind. I'm glad you had this experience! You did a wonderful job of observing both patient and resident closely, and grasping the momentousness of what was happening between them and the skills the resident was using to make it happen. Alexandra, I agree wholeheartedly - this is indeed a glimpse into the center of what family medicine is all about. Here you see a resident who is able to adapt his/her approach to the needs of the patient - rather than simply telling the patient what to do, the resident asks, what do you need from us? The resident involves the patient and she responds positively. The resident is also able to help the patient understand the "big picture," the WHY of her misery, which may help her toward adherence with recommended medical treatment. Finally, I suspect the patient began to feel because of the resident's "enthusiasm" that this doctor actually cared about her, and she responds in kind. I'm glad you had this experience! You did a wonderful job of observing both patient and resident closely, and grasping the momentousness of what was happening between them and the skills the resident was using to make it happen.

Comment #1

Of course you are absolutely right that there is no impermeable barrier between our personal lives and our professional ones; and each influences the other, sometimes for good and sometimes for not-so-good. The best way to deal with these "flows" is to be self-aware and to intentionally commit to being as present with your patient as possible, exactly as you did.

Comment #2

I am always curious when a patient responds in this way. Why is she so combative? What underlies her hostility? Is it fear? Something else? Until you understand this, epidemiology and facts may not get at the issues contributing to her behavior.

Comment #3

Excellent work on yourself, which enabled you to connect with your patient. It is entirely natural to feel frustrated and upset by a patient's hostility. The important thing is to be able to take the next step, let go of defensiveness and self-justification, and be sincerely interested in what might explain the patient's behavior.

Comment #4

What a lovely outcome. This doesn't always happen sadly, but you give the encounter the best chance of resolving in this way if you manage your own negative emotions, refuse to abandon the patient, and just persist in trying to get to the bottom of what is driving the patient to resist your efforts of help.

Comment #5

I appreciate your self-awareness and honesty about how personal issues that you were dealing with made it hard to empathize with this hostile and resistant patient. I love that you initially committed to focusing on the patient's needs; and later in the interview, were able to curb your completely understandable desire to just move on and instead recognized that fear, as it so often is, was at the bottom of the patient's response. By hanging in with her, you were actually able to help her accept a beneficial course of treatment. You are quite right that it takes extra effort and energy to not quit on a patient who is obstinant or uncooperative; but as you discovered, persistence on the physician's part can lead to rewarding outcomes. You may also discover that, when you focus less on how frustrated you are and more on how interesting the patient's challenge is, you may feel less drained and more motivated to keep going.

Comment #1

This must have been so frustrating for the team. I wonder what was the source of this "stubbornness" and refusal of care. Did she hate hospitals? (many do!). Was she frightened that being in the hospital forced her to confront the seriousness of her condition?

Comment #2

This was a pretty challenging assignment for you! It's possible that the resident handed this to you because she or he really had no idea how to achieve this end either.

Comment #3

You know, you may have tried this, but sometimes, instead of disputing ("the nurses do so have your best interest at heart"), it is helpful just to listen, so she can begin to feel someone understands and hears her, even if they don't necessarily agree with her.

Comment #4

challenging situation extremely well. Your resident was right to send you in on the front lines! Despite your own feelings of frustration and even annoyance, you managed to adopt a nonjudgmental attitude, and simply listened. By listening, you started to understand. Although the patient was not behaving in a very appropriate way, we can begin to see that her suspicion, resistance, and uncooperativeness stemmed from fear and loss of control. Knowing the root issues driving this patient undoubtedly made it easier to persuade her to say a bit longer in the hospital. Really impressive work!

Comment #5

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Comment #1

Very astute, you recognize both the medical and the psychosocial negative consequences of this inappropriate action on the part of the physician.

Comment #2

As you observe, if the physician accepts Medicare or Medicaid funding, s/he is obligated to provide language services. Even if the physician does not, it is morally unacceptable (from my perspective) to simply tell a patient to "find a Spanish-speaking doctor." It is the physician's obligation to care for the patient, not the patient's obligation to care for herself. You observe insightfully that not only

might this behavior have endangered the patient's wellbeing, it likely damaged her trust of physicians generally. I wonder if you and your attending were able to do any reparative work in this regard. As you point out, such an experience indeed makes the job of other physicians who follow that much harder.

Comment #1

These are thoughtful questions. I encourage you whenever possible to make the time to ask patients what went wrong in an encounter - this is how we learn.

Comment #2

Your feelings of guilt toward the patient and worry about making your attending look bad are a sign of your conscientiousness. I hope you did not beat yourself up too much, however, these are the stumbles we all make, and the important thing is to learn from them - understand what went wrong and how it can be avoided in the future.

Comment #3

Glad you felt better and could continue with your work. Also glad you developed even greater sensitivity to how questions can trigger defensiveness in patients.

Comment #4

your intention was of course entirely benign; and indeed you had some medical need to understand more about your patient's background. However, taking a step back, it is also true that sadly this question and its variants, which at one time might have merely expressed interested curiosity, have now acquired a subtext of racial or cultural bias, xenophobia etc. If it was important for a diagnosis, or simply because you wanted to learn more about your patient, it might help to preface the question with its rationale: "Some diseases are endemic to certain countries. It might help us better understand what's going on if you could let us know the where you were living when you got the tubes placed." Many people feel that they will be discriminated against, even in healthcare settings, because of their country of origin or religious beliefs.

Comment #1

This inconsistency makes me curious about what is going on with the patient. He is seeking help (or opioids?) since he comes to the hospital, yet he will not permit a PE. Is it drug-seeking? Is he simply

ambivalent about the healthcare system? Why is he angry? Because of pain? Because he is not getting the meds he wants? Lots of questions to puzzle out, not to mention his diagnosis.

Comment #2

This suggests to me he might have been worried about receiving less than top-flight care, a common misperception when patients perceive they are being cared for by "learners" rather than "real doctors." .

Comment #3

I wonder how to explain the difference in behavior toward you and toward the senior resident. This shows he was making conscious choices about toward whom to express anger, and toward whom to express gratitude. What did this difference mean?

Comment #4

A very professional and mature response. I agree, this is the ideal. A good doctor should not be reactive to the bad behavior of the patient, but be able to extend compassion with the thought that you express, that they are going through difficult times and may not be their best selves.

Comment #5

you reached a very responsible and professional conclusion, but I was left with many more questions than answers. Was the patient drug-seeking? Was that the crux of the tension, and why he was so angry with the anesthesia pain team? Was his gratitude toward some but not others "splitting" or was it sincere? Did you feel there was a thaw in his relationship with you, or did he remain hostile and suspicious?In any event, I love the idea of a patient giving honest feedback to his doctors. In fact, I often recommend that residents ask their patients to let them know how they (the doctors) are doing in their care of the patient (they rarely do). This gives the doctor/team an opportunity to understand the patient's perspective better. The "picture" painted may not be accurate, but it does represent the patient's subjective experience, so is well worth hearing.In the end, as you wisely conclude, patients are going through a lot. They are fearful, angry, helpless, out of control, and can perceive themselves as at the mercy of a callous healthcare system. These dynamics often lead to poor interpersonal behavior. The doctor's responsibility is not to get "hooked" by such interactions, but rather continue to be patient and available, not judging, setting limits when necessary, and always trying to understand her patient.

Comment #1

I very much agree with you. I too have observed the negative consequences of providers relying on their own limited language skills or those of family members, who may also have their own discomforts or agendas.

Comment #2

It is complicated, and there is probably no definitive answer; but on balance I agree with your preference to use professional, trained interpreters. Family members/friends do not always have the language skills themselves to adequately translate; and sometimes have their own sensitivities or biases or agendas that interfere with an accurate translation. On the other hand, the presence of trusted family and friends can be reassuring. I think the best approach is to affirm the value of the accompanying individual, thank them effusively for their commitment, and perhaps, if they seem especially reluctant to relinquish their role, carve out some kind of way that they can be involved and add anything to the interpreter's efforts (unfortunately, even trained interpreters also leave out important stuff and can make mistakes. I think the goal is to ensure the best possible communication - and this means both accuracy of content and comfort of patient. What you want to avoid, if possible, is a top-down exercise of your authority, forcing the patient into a situation which will increase her anxiety and diminish her sense of safety.

Comment #1

Good observation on your part. A great question to think about is always, what does the patient need/want from me? You can't always provide this, but the awareness is helpful in figuring out what you CAN do that might approximate the patient's expectations.

Comment #2

Okay, I have to set my veil of neutrality aside. These are not professional comments, from an attending to a medical student or to anyone for that matter. The physician sounds very frustrated, which is understandable, but the object of his/her upsetness should not be the patient.

Comment #3

Interrupting can feel like it's saving time, but it does not. The patient feels unheard, and will keep circling back to their point. Plus interrupting is just rude. Sometimes patients' discourse needs to be redirected, or even cut short gently, but interrupting is rarely the right way to proceed.

Comment #4

Right - the physician is rushing not to see other patients, but because s/he does not enjoy being with this one. The feeling of wanting to get out of the room, of wanting to get away from the patient, should be a cue to explore one's own feelings and behavior, and after taking a deep breath, try practicing curiosity and caring.

Comment #5

as you realized, this was an example of a physician behaving badly - as we all can. In this case, the attending was not a good teacher to the medical student, and s/he was not a good doctor to his patient. Patients can be frustrating, especially when the physician does not have a clear diagnosis or cannot provide clear answers or easy fixes. However, this is not the patient's fault, and the patient should not be punished. Patients should always be treated with respect and dignity, even when they are irritating or demanding or whatever. That is just part of the contract with the physician. This does not mean the physician cannot disagree with the patient or set boundaries, but nothing justifies, not listening, interrupting, rudeness or trivializing the patient's concerns.Further, it is never appropriate to make demeaning remarks about a patient to staff, colleagues or learners. Often this happens with the justification that the physician needs to "let off steam." The steam build-up is perfectly understandable, but the physician should find another mechanism. Such comments create a negative mindset about the patient, and in fact enlist the other members of the team against the patient. This is simply morally wrong.I'm glad you realized that this was an unacceptable way to treat a patient. If you felt this attending was having a bad day, it is something to learn from and let go, although perhaps the patient could be comforted and reassured that she was not "wrong" or "bad" for having pain. If, on the other hand, this behavior was typical of the attending's interactions with patients, it is worth considering whether it should be brought to the attention of the clerkship director.

Comment #1

It does seem illogical, but in the absence of evidence of physical abuse, it is not possible to keep the minor away from the situation until a more extensive investigation, i.e., CPS, establishes a credible threat. As you've seen, that can take a long time, time that the patient doesn't always have.

Comment #2

So what you've learned is that the parents have a very different perspective. Bringing the medical and family points of view together will not be easy.

Comment #3

I'm afraid I have to agree with you. Hopefully CPS will continue to investigate and make recommendations that can help this kid and his family.

Comment #4

This is a particularly dreadful story, truly devastating. In this case, the hospital and the system failed this patient. Even though you are only a third year student, it is natural to feel complicit in what happened to this woman.

Comment #5

Unfortunately, this is a very true statement. You have run up against the painful reality of one of the many ways in which medicine is limited. Figuring out how to always push the boundaries of medicine forward while accepting its current shortcomings and failures is a very hard but essential task of medical professionalism, especially in terms of avoiding burn-out and compassion fatigue.

Comment #6

you are wrestling with a very difficult issue that has no easy resolution. In both cases you (the psych team) were unable to provide the necessary resources for desperate patients. The resources that you did provide did not function as they should. The result in one case was patient suicide. This is a very heavy burden to bear; and in both cases, I hope the psych team was able to debrief emotionally about this tragic outcome. Despite having to face the limits of medicine in this way, it is important to find a way forward that does not reduce you to a technician but rather preserves your compassion and humanity. I think in the last sentence of your essay you are finding your way. Medicine does a lot of good, and acknowledging even small successes helps you keep the balance and enables you to sustain hope

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Comment #1

Yes, I agree, this must have been so frustrating. I wonder what you think their perspective was - how were they viewing the situation?

Comment #2

So that it was harder to care for your patient appropriately, which should be your primary concern, because the daughters were trying to control the situation and express their desires, rather than those of the patient.

Comment #3

Anh, this sounds like an incredibly frustrating situation, and I feel tense just reading about it! Once patient/family start threatening legal action, it is very difficult to have a constructive patient-doctor relationship. I have many questions, which I hope we can discuss at our session: 1) Were there family conferences involving the daughters? 2) Was the patient unable to express his wishes, or did he simply defer to his daughters? 3) At what point did this situation go off the rails? Did the family arrive so angry and upset? Was it the suggestion of the colonoscopy that distressed them? I suspect that this was a situation in which it would be very difficult to achieve a positive interpersonal outcome. Nevertheless, I wonder if there were any steps that could have been taken to align with the daughters and make them feel part of the team. What would the daughters have said about their experience? Was there any way in which their needs (including their emotional needs) could have been better met?

Comment #1

This is a common error with older patients - directing most of the conversation to the care-giving family member. What is especially disappointing is that, even when the husband and the patient herself tried to direct interaction toward her, the resident persisted in interacting with the husband only.

Comment #2

The resident damaged trust between him and the patient; and then proceeded to conduct a very sensitive and difficult exam. It's not surprising things did not go well. Showing his annoyance is of course highly unprofessional. It's a way of punishing the patient.

Comment #3

this is one of those examples of a negative role-model from which you learn what NOT to do. Not speaking to the patient, not providing patient and kind instruction to prepare for a difficult exam, and expressing displeasure (even nonverbally) at the amount of time the assessment was taking are all unprofessional ways of acting. I agree that the resident was likely not having a great day, but it is precisely at those times that the physician has to check his or her own behavior and exercise some restraint. It's a mental and attitudinal discipline to be sure, but a highly necessary one. Taking a breath, focusing on the patient's perspective, reminding oneself of one's own values and other strategies can be effective in getting oneself back on track.

Comment #1

This is very illuminating. Thank goodness you had your mom around to suggest these possible and plausible reasons for the wife's behavior. In any encounter, and especially so where differences of culture, language, religion are involved, many things can be difficult to understand. When one's mom is not available :-), sometimes it is helpful to respectfully and humbly ask the patient or family member for help in understanding what's going on.

Comment #2

I like your self-awareness that in this particular situation, you didn't have enough self awareness :-). It is so easy to get caught up in "the business of clinic." And of course the "business of clinic" is vitally important as well. But taking that moment for reflection, for recognizing things are happening that you don't really understand, can make a big difference in patient care.

Comment #3

Asking permission before conducting a physical exam, or broaching a sensitive topic, is ALWAYS good practice. It shows respect for the patient and humility (rather than entitlement) on the part of the physician.

Comment #4

I thought it was great that you "consulted" with your mom about this encounter; and she certainly had some insightful comments to make.I also appreciated that you realized you had noticed uncomfortable and inexplicable behavior in your patient's wife, but hadn't stopped to ask yourself what it might mean. it is really hard to introduce that extra layer of awareness in our daily lives, but when we do, the pay-off can be significant. The more we can pay attention to the emotional tenor in the room, the more we can clarify why people do what they do, the better job we can do of taking care of others.Finally, your commitment to asking rather than telling is a wonderful guideline to follow in clinical practice. It restores a modicum of control to patients, it shows respect, and it is an act of humility. What a great lesson to have learned!

Comment #1

Excellent job of defining your role as the medical student. It sounds as though you were able to elicit his fears, vulnerabilities, and life story while not allowing him to engaging in splitting between you and the rest of the team.

Comment #2

An empathetic and insightful remark. Borderline personality disorder makes people impossible to live with - they drive everyone crazy, and it is very difficult for them to sustain meaningful relationships. But what is it like for these individuals, who have little insight into their problem, to be disappointed continually in their relationships, to be lonely, and alone?

Comment #3

Well done. If you think of BPD as a very difficult-to-treat medical condition, then it is possible to feel compassion for this individual, despite his self-destructive and aggravating behavior. You took the right tack with this patient. Even though this might not have been very satisfying, it was the best chance you had to take care of him.

Comment #4

you describe a very frustrating situation. Your patient is dealing with a huge medical burden. In addition, his personality disorder (and who knows, possibly PTSD as well), have destroyed any social support system he might have had. It is tragic.One thing I wondered about was the source of the patient's confrontation and lack of cooperation. Had he given up? Was his life no longer worth living? Was this behavior a way of trying to maintain control when so much of his life had moved beyond his control? In attempting to address problem behavior, the first step is always trying to deeply understand its origin. At this point, after a lifetime of dysfunctional patterns, there is probably not too much to do in terms of turning around his care. Nevertheless, your obligation is to try, as you and the team clearly did. You identified and put a stop to his splitting behavior, a good move. The staff tried negotiation, which seemed to have some good effect. Finally, as the medical student on the team, you tried to connect with his humanity, vulnerability, and suffering, and to soothe his suspicions and mistrust. I really admire how everyone behaved, and hope that it led to an amelioration of his antagonistic behavior.

Comment #1

Okay good, a well-defined moral dilemma, and one that physicians confront all the time in one form or another (eg., drunk driver who emerges unscathed after wiping out a family). Society agrees that all, even criminals and bad people, deserve healthcare. Empathy arises because of the suffering of another human being. Where does judgment fit in?

Comment #2

Your essay implicitly poses intriguing and important questions. From where does that "distaste" arise? Do other doctors perhaps feel distaste toward patients due to other factors? How do we reconcile sympathy, if not empathy, for their current suffering and plight with such distaste? What might be the implications of such distaste? The physician is not going to like or admire every patient. Does this matter so long as appropriate care is provided? (which in this case it might not be, because of this patient falling into insurance coverage limbo). There are no easy answers to these questions, perhaps no answers at all, but they are worth pondering, because you will confront them again and again.

Comment #1

This is an interesting - albeit aggressive - comment. It sounds like she put a great deal of time into writing this document, and wanted to make sure it was acknowledged. How might you have opened the encounter a bit differently with this knowledge?

Comment #2

So she seems to feel that her time is being wasted. Do you think it would help if you made this concern explicit? There is a lot of redundancy and repetition in medicine. Sometimes explaining why it's there and how it might benefit the patient can reduce some of the patient's annoymance.

Comment #3

Very perceptive and honest. How can you answer a question that has no answer? Again, sometimes the answer may lie in validating the question and honestly acknowledging the limitations of medicine. It may also help to figure out what questions you CAN answer (can we figure out ways to reduce the pain and/or make you more functional?)

Common #4

This sounds like an upsetting encounter, yet there is lots to be curious about. Why did the patient prepare her detailed summary? Did she feel previous doctors dismissed her concerns and did not take her seriously? She seemed looking for a fight. Does she feel her doctors are her enemies, and she needs to do battle with them to get the care she needs? The issue of the "unanswerable" questions intrigued me. There are lots of these questions in medicine and doctors usually don't like them, because they are used to giving answers. But sometimes a worthwhile dialogue can grow up around a question that has no answer. What is the question behind the question? Perhaps "I can't

stand this any longer," or "How can I find relief?" or "Who will help me?" Exploring such questions may provide the patient with support and hope, even in the

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Comment #1

You are similar in age, gender, being the children of immigrants, and having struggled with weight issues, but there were also many differences in your life experiences that are anchored in the cruel fate awaiting many Latino immigrants in this country.

Comment #2

No it cannot. It is impossible to practice good biomedicine in a vacuum as the forces of structural racism and xenophobia that you mention clearly impact almost every aspect of patient care.

Comment #3

Probably not a bad idea :-) And when you do, you will have easy access to excellent doctors, will have no worries about how to pay for your visit or any medications you need, and will not spend sleepless night worrying whether La Migra might somehow track you down as a result of that visit. I point out these things not to make you feel guilty, but to say that along with privilege comes responsibility to try to ameliorate the unfair and inequitable circumstances of others. Clearly you are committed to this mission already.

Comment #4

I really liked your essay. I liked the way you immediately saw the similarities and differences between you and your patient. The similarities no doubt made it easier for you to form a connection and have a good relationship. The differences have allowed you to become a doctor, while your patient is trapped by his societal and socioeconomic circumstances to work a stressful job and live an unhealthy lifestyle. Recognizing these upstream problems hopefully inspire a deeper understanding of the forces shaping health and illness in this country, and at the least avoid simplistic and demeaning treatment plans that ignore the patient's life realities. Such awareness also lead to a commitment to make healthcare more equitable and more just, which is implied.

Comment #1

Of course, you presented the mom with correct information. Why do you think she laughed? What might you have taken into consideration in deciding how to approach this problem?

Comment #2

So what's going on here? You have an interesting hypothesis that this mom thinks she's above the rules. This is what needs to be discussed.

Comment #3

Although in some respects this is a unique situation, in the course of your medical career, no matter your choice of specialty, you will have patients who are also physicians. This presents many challenges because, understandably, doctors want to remain doctors and do not want to become patients. The resistance and desire to remain in control that you encountered with this physician-mom will be dynamics that you will encounter in other physician-patients. How to navigate them is tricky and not always possible, but generally has to do with honoring the patient's expertise, enabling them to control as much of their care as possible (the small things matter), while being clear that you are their physician.

Comment #1

What does it tell you when a patient keeps returning to a topic? It sounds to me as the "ear pain" was what the patient used to get in the door; but his real concern was his concern about cutting back his narcotic meds.

Comment #2

Good insight, the patient and the attending had different agendas in this encounter. When that occurs, how might it be handled? How you can create a shared agenda?

Comment #3

Good awareness - everyone is feeling resentful of the patient. How might those feelings affect the patient's care? What should staff and attending do with those feelings? How might they be mitigated?

Comment #4

Patients who are addicted/dependent on narcotics are obviously a difficult population to care for. Did you feel this patient was trying to do an "end-run" around the pain specialist? How could that be addressed?You observed perceptively that doctor and patient had different agendas. Might it be possible to find common ground? How can differing agendas be reconciled? You also noted the frustration of the medical team. This is very understandable. However, is it possible such feelings might adversely affect patient care? If you notice feelings such as annoyance, resentment etc. in yourself or in others, how should they be managed?

Comment #1

This was quite sensitive of you, and in general it is a good assumption; but sometimes shared culture or gender does not guarantee culturally-aware, empathic approaches.

Comment #2

Excellent point and I am in agreement. Especially in these times, it is easy for people to feel judged or disparaged - having someone who shares a similar cultural background can serve to mediate between patient and doctor.

Comment #3

you raise an interesting and pertinent issue: what to do when a patient's/family's cultural beliefs are in conflict with best medical practices. As you did, starting not with the negative but with interested curiosity and a desire to understand is always a good idea. Then a genuine statement of your concern puts the conflict on the table. Finally,instead of telling ("baby can't wear this jewelry") ask for ideas ("I know we both want the best for baby Dattesh. What are your thoughts?").

You are absolutely right that a physician or other health professional who has familiarity with the culture and traditions will likely be perceived as more trustworthy and may succeed better at putting the patient at ease. I'm glad you recognized that the attending might be in a better position to negotiate this issue. I hope, however, that you learned from observing her, so that next time, if there is no one available culturally similar to the family, you would be able to handle the conversation with respect and sensitivity.

Comment #1

Yes, this is a very difficult problem to address, especially when the patient does not perceive there is a problem. It's a fine balance between not colluding with the patient in ignoring the issue; and not futilely nagging or brow-beating the patient. Motivational interviewing can be useful in eliciting the patient's state of readiness to change.

Comment #2

This sort of ambivalence in patients is not uncommon, as you've no doubt seen. The patient both wants and doesn't want help. The key is to help strengthen the part wanting help.

Comment #3

In one sense, this is quite true. However, in a primary care setting, groundwork may have been laid. The patient may leave thinking over what a prostate exam would be like and whether the additional information obtained would be worth the discomfort or embarrassment.

Comment #4

This question is a reflection of the doctor's frustration, and his need to see measurable "progress" in the patient. This is completely understandable - this is exactly what most doctors want. But in some cases before the patient can "get better," there has to be an honest interaction. "Let's talk about your drinking." "Help me understand what you want from me as your doctor." These "meta-conversations" are usually not necessary in healthcare, because doctor and patient are more or less on the same page; but when the care of the patient becomes "stuck," this becomes the biggest problem in the room and needs to be addressed directly

Comment #5

you brought up a couple of really interesting points. One is the difficulty of treating a patient who is abusing alcohol, especially when the patient does not agree he has a problem. As noted, motivational interviewing can be helpful in strengthening or at least clarifying the patient's desire to change. The other frustrating issue is when the patient both asks for and rejects help. This is not that unusual because patients both want help and are afraid of it. Again, the key is to nonjudgmentally explore this ambivalence, to recognize the dilemma the patient faces, and to see if there is a way to help them past it. Empathizing with the patient's concerns may help both of you to figure out how to move forward.

Comment #1

It's interesting that when healthcare is structured differently (e.g., in the Integrative Medicine clinic), different interactions can develop and different information and insight can be obtained.

Cmmment #2

A perfect example of how the social and structural circumstances of one's life can impact health.

Comment #3

I thought it was interesting that this woman did not fit the stereotype of the undocumented immigrant, and had the advantages of (presumably) being white and speaking English well. Nevertheless, her undocumented status weighed heavily on her, contributing to fear and stress; and her lack of health insurance was compromising her care. It is a good reminder that physicians cannot practice in a biomedical bubble. All aspects of care of their patients are affected by structural racism, xenophobia, gender bias, sexism, ageism, ableism and other systemic factors that contribute to health inequities and injustices.

Comment #1

Nice. These are some of the patient characteristics identified in the literature. Of course, there are also physician characteristics that should be taken into consideration - for example, physicians who are lower in empathy or less interested in the psychosocial and structural circumstances of their patients.

Comment #2

I agree, these complex patients with no path toward cure or sometimes even significant improvement in their condition can be very difficult to manage.

Comment #3

I agree - I'm not confident an endocrinologist is going to solve her diabetes. Your insight is correct in my view - she must be helped toward getting these other stressors under control otherwise her diabetes will not improve.

Comment #4

You are absolutely right that patients with complex medical, social, and structural problems are highly disadvantaged to be able to effectively manage their chronic medical conditions. I wonder if the attending considered referral to an onsite therapist or social worker (if this patient was seen at FHC-SA) or to a group medical visit (also available at FHC-SA) or a diabetes education group or even a healthy eating group. It seems to me the patient needs more support to address both her own psych issues and to help her manage the care of her mother. Basically, the patient might benefit from a larger team approach that could relieve the primary physician of some of the burden of the patient's care; while identifying resources that could offer her support, social interaction, and hope.It's also important to think about how you can cope with and ameliorate your own feelings of frustration. Of course, they are completely understandable and natural; yet they may also adversely affect your relationship with the patient. Learning how to recognize and transform frustration is a

valuable practice involving being cCarina, you are absolutely right that patients with complex medical, social, and structural problems are highly disadvantaged to be able to effectively manage their chronic medical conditions.I wonder if the attending considered referral to an onsite therapist or social worker (if this patient was seen at FHC-SA) or to a group medical visit (also available at FHC-SA) or a diabetes education group or even a healthy eating group. It seems to me the patient needs more support to address both her own psych issues and to help her manage the care of her mother. Basically, the patient might benefit from a larger team approach that could relieve the primary physician of some of the burden of the patient's care; while identifying resources that could offer her support, social interaction, and hope.It's also important to think about how you can cope with and ameliorate your own feelings of frustration. Of course, they are completely understandable and natural; yet they may also adversely affect your relationship with the patient. Learning how to recognize and transform frustration is a valuable practice involving being curious about the patient's life and being fully present during the interaction, which I hope we can discuss further in class. curious about the patient's life and being fully present during the interaction, which I hope we can discuss further in class.

Comment #1

I wonder why this is. If a patient has failed to show up "countless times," what is going wrong? How should such a patient be approached to ensure better medical care?

Comment #2

you did a great job of noting certain worrisome signs and inconsistencies in your patient, and in obtaining a detailed social history that revealed the many psychosocial problems of this patient.. I'd like to hear more about how you put the puzzle together, since I'm still confused! :-) One thing in particular did give me pause. She has a grossly enlarged uterus and has been told on numerous occasions that she needs surgery. Yet she does not follow through. WHY? Is she afraid? In denial? No funds? Lacks capacity to deal with her diagnosis? It was distressing to read that phrase "countless times" and think of all the opportunities that existed to help this patient that fell by the wayside. I wish someone along the way had taken the time to work with this patient's puzzle as you did, and perhaps would then have been able to provide better care for her.

Comment #1

What do you think was the disconnect here? Did she not want a student, but was afraid to say so? Did she seem biased toward you in some way? Was it a lack of trust?

Comment #2

This is a key question I was wondering about as well. What did the patient want? What did she need? Sometimes, when we can't figure this out, it an help just to ask.

Comment #3

I'm not quite sure what you're referring to here, but there are definitely examples of racism and other prejudices in patients, and it's important to figure out how such incidents should be handled in a way that does not jeopardize the care of the patient but also protects the wellbeing of the provider.

Comment #4

This is of course true. However, in continuity care situations, if the patient comes back, there is always another opportunity for helping. Sometimes it takes more than one visit to figure out how the patient can be helped.

Comment #5

thank you for this thoughtful essay. Sometimes medicine is not nearly as clearcut as you think as an MS1 or MS2, right? You raise many important issues: 1) how to assess a patient's psychiatric needs and make a referral in a way that does not completely alienate the patient 2) how to earn trust in a patient who is suspicious (even without psych issues) 3) how to deal with racism or other bias in a patient 4) how to decide whether you have reached your limits in terms of helping a patient; and if so, how to accept this without blaming the patient. Each of these requires extensive examination, and I hope we can address at least some of them in our discussion.

Comment #1

I absolutely agree with you, it is no excuse it all. This is very bad behavior. Nevertheless, my curiosity is piqued. What is going on with this patient? What are these "underlying factors"? Why is he berating you? Finding out the answers to some of these questions might show a way forward.

Comment #2

Yes, it sounds like a very difficult situation that resulted from the clinic being short-staffed. Normally, from your description, there is a system in place to better protect the student, but in this case, it failed. I'm so sorry, you should not have been subjected to this verbal assault.

Comment #3

this was clearly a very unpleasant encounter, and you would be within your rights as a student to simply say to the patient it's obvious he does not want you to be there, tell him he will have to continue to wait for the doctor, and leave. You can also think about to what extent your reaction to a patient is determined by their behavior. This guy is escalating - can you de-escalate? Can you match his "furious" with your "curious"? Can you ask his permission to let him know how your talking to him might actually improve and speed up his care - and then he could decide? It is a sad fact of medicine that you will encounter more than a few angry patients who are being unfair to you. In medical school, depending on the circumstances, it can be an opportunity to practice how you will manage such patients in the future. Of course, if you feel threatened in any way, physically or verbally, it is better to step out. I'm sorry you were subjected to this profane wave of undeserved indignation. Sometimes the medical student is the only dog the patient can kick (which is an explanation not an excuse)

Comment #1

This makes it sound as though, even if there had been no miscommunication, the pt might have abandoned the antibiotics because he could not tolerate the side effects.

Comment #2

Explaining your perspective to the patient is obviously very important. Of course, it is equally important to listen to his perspective - why did he choose to ignore your advice? What was driving his choice to risk serious spinal infection? Without understanding this, explaining may not be enough.

Comment #3

this is a very interesting case. On the surface, the "right choice" seems obvious: a little itching vs. possibly life-threatening complications. Yet we know that itchiness is one of the most unpleasant, sometimes unendurable sensations known to humankind. It might well be that the immediate problem trivial as it seems to someone "outside" the situation is more important to the patient than the possibility of more serious complications down the road. Many people have difficulty grappling with long-term consequences vs. short-term gratification (think diabetes or hypertension). I wonder what the conversation with the patient was like and what options were offered him. How did he understand the risk/benefit ratio? What was his thinking that led him to this decision? Was this an informed choice or merely a desperate attempt to relieve an unbearable sensation? Perhaps he could have been persuaded with more time and more listening; but perhaps he was sufficiently

confused and uncomfortable that no amount of dialogue could have changed this very concerning outcome.

Comment #1

Mistake #1. An effective family conference should generally start with listening, to find out what the family knows and what their priorities are.

Comment #2

Mistake #2. The palliative medicine doctor might have had a strong conviction about the rightness of his recommendation, and this could have come across as accusatory. This is a very common pitfall, and will put the family on the defensive, as though they have done something wrong or failed their loved one in some way.

Comment #3

This is a very unfortunate outcome, and probably could have been avoided if, as you suggest, a gentler, more open approach had been employed.

Comment #4

Mistake #3. When there is tension or sadness or anger present, it should be acknowledged. When emotion is intense enough to be noticed, it has become the primary presenting problem, and needs to be addressed before the interaction proceeds further.

Comment #5

Mistake #4. It is tempting to try to ignore uncomfortable moments in an encounter, but in medicine there are many, so it is important to become comfortable with discomfort. When the family is confused, this is something the physician should notice and address. It helps for the physician to take the initiative and ask directly, "Is there anything I've said that doesn't make sense or isn't clear? It's important to me that we understand each other as clearly as possible."

Comment #6

You obviously were paying careful attention during this encounter, and learned a lot of important lessons. One of the most important ones is the one you mention at the end - to read the patient/family and, if they seem distressed, address the issue and modify your approach. Essentially, take a mulligan - apologize, and start again. The good thing about making mistakes in the psychosocial dimension is that no one is going to die, and you can try again, as long as you are humble enough to admit error.

Comment #1

Yes, of course. Doctors are almost always motivated by a sincere desire to help, and it can be painful when the patient rejects or does not appreciate that help. Yet rarely is that rejection about you personally; much more often it has to do with other issues the patient is struggling with. By understanding what is making the patient behave in such a curt, unfriendly way, you may be able to make some headway with her.

Comment #2

Good insight. Now you are examining the patient's perspective, which is that she thinks these questions are stupid, and just a barrier to her escape. Knowing this, you may adjust your approach.

Comment #3

What a great conclusion. If you regard a "failure" experience as an opportunity for learning, you will not need to be so discouraged. Instead, you'll feel the tiniest bit of curiosity. What is going wrong and why... and how can it be tweaked?

Comment #4

Your first reaction to your patient's curt, unfriendly answers was to be hurt. Completely understandable, who among us likes rejection, especially when we are only trying to do good? But impressively you didn't stop there. You thought about the patient's point of view, and what might be driving this unkind behavior. Then you thought about different ways you could connect with her, and risked a different approach. The result was that you developed rapport and won her trust. You learned the valuable lesson that, while there are treatment protocols for diseases, there is no one algorithm for human interaction. You have to be attentive, curious, nondefensive. You have to be creative and ready to improvise. You handled this difficult situation with sensitivity and skill.

Comment #1

Unfortunately, this shift of attention to the English-speaking family member happens all too often. You can see that the attending started off with good intentions and was doing well; but as the interview progressed, she lapsed into interacting in a way that was easiest for her, although less optimal for her patient.

Comment #2

I'm glad that, due to the doctor's recontacting the patient, the patient regained her sense of trust. However, whenever possible, it is better to keep the patient fully engaed in the interaction.

Comment #3

this was a carefully observed interaction in which you showed yourself to be sensitive to and aware of the subtle nuances of the patient-son-doctor dynamics. I agree with you completely that as the physician shifted her focus from mother to son, the patient disappeared from the interaction. This can happen unconsciously, simply because it is easier and more comfortable to converse with someone who has no language difference from yourself. Yet the effects on the patient can be significant, as you saw. Fortunately, in this case, the patient's trust and cooperation did not seem damaged longterm. Yet we should not rely on patients' goodwill to compensate for our shortcomings. This is an example of one of the "small" things that can happen in a patient encounter that many physicians ignore which nevertheless can make a big difference in the way the doctor-patient relationship develops and treatment proceeds.

Comment #1

I agree with your conclusion. I am sure it is difficult from a financial perspective to figure out a cost-effective use of interpreters. But in a multicultural society where not everyone is going to speak English, greater investment in interpreter resources is essential.

Comment #2

This essay does an uncomfortably good job of capturing the incredible frustrations that can arise in trying to practice medicine across language and culture. In these cases, t is very difficult to provide optimal care without an interpreter who can act as a cultural mediator and, importantly, can gain the patient's trust. While not impossible with the phone translator, the disembodied voice makes achieving these goals much more difficult.

Comment #1

Good approach. You are trying to show the patient that this isn't just a waste of his time, that you can actually be helpful in presenting information to the doctor to highlight certain key issues and shorten the visit.

Comment #2

I appreciate that you took a patient-centered approach to this situation. However, it also sounds like you felt pressured to be "quick" with the patient so as not to slow him down. This was sensitive to his need to move on to his next appointment. On the other hand, you don't want to be rushed to the extent that it impairs your history-taking or case presentation. By informing the attending that the patient needs to be at the cardio clinic at a certain time, you can mutually decide whether it is worthwhile to spend limited time with the patient. If you do, the attending will likely make allowances for your limited information; and the patient will appreciate that you are trying to get him out in a timely manner. Bottom-line, however, if you must choose between your learning and the patient's needs, in my view you are right to prioritize the latter.

Comment #1

I will be interested in hearing specifically how religious and cultural factors intersected with the patient's concerns. Was it that IVF was frowned on for religious and cultural reasons?

Comment #2

I was impressed with your succinct yet thorough summary of the patient's concerns. I was not entirely clear about whether the parents' disapproval of IVF was based on religious and cultural factors, and look forward to learning more. Further, I'm curious whether it was necessary to take any further steps other than reassuring the patient that you would maintain her privacy on this issue. I'm also wondering whether it was necessary to allay her anxiety in any other ways, or whether she was able to manage once she knew her health information would be protected.

Comment #1

That's a brave statement and one with which I couldn't agree more. You need to know the protocols, because they are there for a reason, and then you need to know when and how to subvert them. "Meeting the patient on their own terms" is the cornerstone of effective, compassionate, and meaningful clinical medicine.

Comment #2

If you take a step back, a truly fascinating exchange. You are trying to follow the HPI you were taught, but to the patient, you simply "aren't listening." Yet clearly the patient is very upset and frustrated. If possible, this is a cue for compassionate curiosity, to want to "learn more."

Comment #3

Well done. There are thousands of these moments in medicine, where something significant is going on, something unexpected, a surprise! - and you have a choice to go on repeating what isn't working or recognize that a new approach is required. I admire that you saw this moment for what it was, and changed the direction of the interview.

Comment #4

I really liked your essay! You are already aware of an important issue in clinical medicine - once you've learned the forms and methods, then you have to know when they need to be set aside. I'm impressed at your judgment that you needed a different approach with this patient. You really heard her - she wanted someone to listen - and once you did just that, she was more amenable to talking about her problem. You may have also discovered important information about manic or somaticizing tendencies that could help you treat her in the future. Or you might simply have returned some control to her in a scary situation.

Comment #1

It is not unusual for patients not only to consult different doctors, especially when their problems do not resolve to their satisfaction, but to seek out help from all sorts of different practitioners. It is important to speak about the treatment plans and ideas of these individuals with respect, even when the doctor does not agree with them. You are all working for the patient's wellbeing, albeit from different frames of reference and knowledge foundations.

Comment #2

I liked many things about your essay: 1) You chose to go in to see a patient even when the attending told you "there was not much opportunity for learning." As you realized, every patient offers an opportunity for learning 2) You were very perceptive about trying to discover the "root" of the patient's concern - what was the question she really wanted addressed? Until you figure that out, you won't be able to have a satisfactory patient encounter 3) You avoided taking sides in the naturopathic/western medicine physician debate. Patients will seek care from anyone they think can help them. Your job is to show the patient what you can offer based on your western medicine-

trained understanding of the problem. 4) You treated a "difficult" patient with "patience, respect, and humility," and managed to keep her at the center of your care. Nice work!

Comment #1

Good insight; and it results from the fact that the good family physician has equal relational commitment to ALL her patients, not just the one in front of her.

Comment #2

It sounds like Dr. W tried many indirect strategies to set limits on the patient, but to no avail. How do you think better boundaries could be established without impairing the patient-doctor relationship?

Comment #3

Control of the interview is an interesting concept. Certainly the physician should have some control. I wonder if the patient should have some control as well.

Comment #4

Yes, this reflection on the encounter suggests the possibility may not have understood the ground rules under which Dr. W. was operating. What seems obvious to the physician may not be obvious to the patient.

Comment #5

your well-observed essay raises interesting questions about control in the patient-doctor relationship. Of course, you are absolutely right that without any control, the encounter runs off the rails. However, it is easy for the physician, with all the power, to slip into an overcontrolling mode. The physician is safest when she or he has complete control of the encounter - imposes his/her agenda, relies on closed-ended questions etc. So it's a balance - ideally, in my view, the physician is willing to relinquish some control, so that the patient's priorities, question, and understanding have a prominent place in the encounter; yet retains enough control so that time is used well and the necessary information is obtained. It is not wrong for patients to share their stories - this may be very important to them - but it must happen within a context that is respectful both of the patient's medical needs and the needs of other patients.

Comment #1

Set-up improves with familiarity, but your observations about disconnection and loss of control of the interview are much harder to correct. Working with an on-site human interpreter it is easier to establish ground rules (but less cost-effective). As you and others noted in our class discussion, looking for additional avenues to establish connection (such as nonverbals, changing the timing of writing your notes, body language and tone of voice) can ameliorate but not completely eliminate that sense of disconnect.

Comment #2

I can hear how disappointed you were in yourself. As we discussed in class, it is great to have high standards for yourself, so long as you can discriminate when you don't meet them perfectly without beating yourself up.

Comment #3

These are all very constructive and achievable ideas. As you noted, you're not going to learn fluent Spanish in three weeks; but by making small tweaks, you can begin to feel less at sea in these situations and make your patients feel more comfortable as well. Nicely done!

Comment #1

It was an excellent presentation, all the key medical details presented in an efficient and well-organized manner. You did exactly what you are trained to do as a physician. I'm sure you are feeling, as am I, that there is no room in that presentation for compassion, righteous anger, or even guilt at all of our complicity in an outrageously unjust and inequitable healthcare system. Too bad.

Comment #2