Comment #1
A very sad story. As you discovered, it's really important to probe the reasons for noncompliance/ nonadherence. Unfortunately, sometimes these terms become code for patients who "don't care about their health." There are so many barriers, both internal and external, to obtaining and taking medications properly - and it is part of being a physician to help them figure out solutions whether psychological, interpersonal, or systemic.

Comment #2
Yes, he may not know how to cook for himself and might not feel it's part of the masculine role. As well, fast food is cheap and convenient, so that for people with limited resources, regardless of whether men or women, it becomes a very tempting, albeit bery unhealthy option.

Comment #3
His receptivity to meeting with a nutritionist is a good sign. I'm glad to see your awareness that there is "a larger conversation" that needs to be had here. Only so much can be done in a single visit; and behavior change is notoriously slow to develop. The value of a continuity relationship is that the family doc can continue to revisit this issue and work with the patient to develop more healthy habits.

Comment #4
I appreciated the way you realized that you made certain assumptions about the patient at the start of the encounter; and then were able to revise them based on eliciting a more complete story and listening to it deeply. Nonadherence is a pretty complex issue. It can be hard for patients to even admit they are not taking their medication. Then there are a myriad of factors, both structural and personal, that may contribute to this problem. In this country, medication is expensive especially without insurance. Patients may have other priorities, such as paying rent or putting food on the table. It can also be hard to patients to acknowledge that they have a chronic disease, and taking daily medication is a constant reminder. Sometimes patients are ambivalent or skeptical about the utility of medication. Etc. etc. Until you know the obstacles, you can not begin to help the patient resolve them.In the latter part of the essay, you mention the patient's expectations and beliefs about how healthy eating happens ("a wife provides it"). It's great you were able to uncover this information. Making changes in one's eating behavior is extremely challenging, and here too many structural factors come into play. But understanding your patient's perspective is the first step toward constructively working to help them make these difficult changes.

Comment #1
I can see you took great care not to replicate the patient's negative experiences with family and society at large in the exam room.

Comment #2 Concepts such as respect and care for the whole person are fundamental to any patient-doctor encounter; and are especially important when the patient has a history of encountering the reverse.

Comment #3
I respect the care and thoughtful attention with which you approached this transgender patient. Consulting with your preceptor took more time but was an important check to ensure that you were meeting all the patient's physical and emotional needs. Demonstrating respect and concern for the whole person (which in this case can be conveyed in part by use of correct pronouns and sensitivity to the male identification of the patient) are fundamental to a successful interaction.

Your essay raised man questions in my mind. For example, did your level of comfort change from the beginning to the end of the interview? Were there any points at which you felt you could have phrased a question with more sensitivity? Were there any moments when you felt you were able to connect with and support the patient? It sounds as though this encounter helped you develop skills and understanding that will expand and deepen how you "doctor" in the future, and I will be interested in hearing more concretely what you learned from this encounter.

Comment#1

I agree - impressive! Sometimes our initial reactions of judgment, shock etc. are not helpful in promoting a trusting clinical encounter.

Comment #2

So this is a very reasonable response. It is not the response per se that is wrong, but what you will do with it as her doctor. For example, if you say, "How can you put all those innocent lives at risk?" (or express this feeling nonverbally), the patient will likely become defensive. However, you might return to this topic and use MI to ask what are the benefits she gets from this drinking; and what might be some of the downsides, it's more likely to stimulate her own self-reflection and lead her to the awareness which you felt instantly.

Comment #3

This is a very admirable attending. Yes, it is absolutely not wrong to think of all the people she is endangering. It is also not wrong to think of how much she must be suffering to engage in this kind of behavior.

Comment #4

I really appreciate your self-awareness and how your initial reaction, while completely understandable and normal, might lead to a disruption in trust and therefore the doctor-patient relationship. Your experienced and skillful attending was able to express both concern and empathy

for the patient while gently raising the issue of other lives. This approach is likely to encourage the patient to continue to face herself honestly. As you perceptively observed, this encounter is the first step in asking for help, and the physician's response will play a large role in determining whether the patient stays on the path, or withdraws into her bottle.

Comment #1

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

Comment #2

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 #3

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

For many patients, changing healthcare providers is an anxious, even distressing experience. This does not excuse the patient's uncooperative behavior. But when such behavior is persistent, and the patient doesn't settle down after simple reassurance, it is sometimes helpful to change the focus of the interview from getting the history to addressing the patient's upsetness directly. Start by acknowledging and validating the patient's distress, then ask if there's anything in particular she's worried about in the transfer. Look for common ground: "I know this is a hassle, and I'm so sorry. We both want to make sure that you get the same excellent care you got at UCLA here at UCI. Can we work together to make sure that happens?"

Comment #2

Of course it is understandable that you would also be frustrated. You are just trying to help the patient, and she is being obstructive.

Comment #3

This may be a pattern, which the attending will have to ascertain over time and deal with. It may also be that she is having trouble adjusting her expectations, and it may take a little more time for her to adapt to this unexpected situation.

Comment #4

I really respect that you engaged in this exercise, Alexandra. It usually provides empathy for where the patient is coming from, even if you still don't agree with them.

Comment #5

I truly respect that despite feeling some anger toward this uncooperative patient, you reflected on the encounter and were able to put yourself in her shoes. From that perspective, and given the fact she is discussing something as sensitive as her health, it is understandable (although not right) that she would react with hostility and pushback when she learned you did not magically have all her records. It's interesting that often in these situations, both patient and provider end up with very similar feelings. It is up to the doctor to try to soften or moderate them in both parties! As I note in my comment in the text, sometimes when the patient is very upset, it is worth interrupting your agenda (complete history) and spending a few moments talking about her feelings - i.e., validating that starting over with one's healthcare is scary, reassuring the patient you and she share the goal of giving her superlative healthcare, and eliciting whether she has any special fears or worries. This can help the patient feel seen and heard, and often leads to her calming down. In doing this, you are really building trust, and this is probably the missing ingredient in the interview.

Comment #1

This seems unfortunate, because the patient is clearly crying out for help and struggling with outpatient care.

Comment #2

Hmm. This is useful information, but it doesn't seem to me the decision to place a patient on an inpatient unit should be determined by whether the patient might leave. This can be the case for many inpatients!

Comment #3

To me, this is the key - or at least a key. (Some of) the psychiatrists sound exasperated with this patient, and probably for good reason. But when patients feel their physicians are "dismissive," the relationship is in trouble. It's always important to take a suicidal patient seriously; even if there is a borderline or histrionic component, these individuals can still kill themselves.

Comment #4

This sounds like a very challenging and frustrating situation, Alexei. The patient was complicated, and dealing with many complicated psychological and identity issues. Some of the physicians seemed irritated by his cries for help. It is unclear to me why this patient did not qualify for inpatient care, but personally I would worry about simple discharge with outpatient follow-up.

I wonder what might have helped build a stronger therapeutic bond. What was this patient's story? Why did he keep wanting to kill himself? What did he hope would happen from hospitalization? There are many unanswered questions, and I suspect that providing him with real help would involve finding more answers.

I think you are right to be disappointed. This patient did not make it easy for his providers, but he deserved to be taken seriously.

Comment #1

Very well-stated description of a perennial problem with which experienced physicians as well as third year students.

Comment #2

It shows you are very attentive and observant about what constitutes a successful conversation. Your point about listening is also well-taken. When patients feel seen and heard, they feel more trustful of their physician, therefore more likely to answer questions and follow treatment plans. Listening is one of the most effective ways of establishing a good doctor-patient relaitonship.

Comment #3

Again, excellent observations. When your goal is to "extract pertinent information" the patient ends up feeling like an object, not a human. The relationship, in the words of the philosopher Martin Buber, is I-It, not I-Thou. As you note, this will lead to the patient feeling vulnerable and powerless (which they already feel because of their illness). This approach seems efficient (which should not be the highest priority of the clinical encounter) but it often actually leads to incomplete or inaccurate information, lack of patient trust, lack of cooperation or compliance - and all these end up taking more time!

Comment #4

You've written a really perceptive essay. Your insights into what makes for a successful clinical conversation are excellent. Listening is the key to a fruitful interaction that establishes trust and rapport.

On the other hand, a utilitarian approach to the encounter, which you describe next, ignores the humanity of the patient (and the provider) in favor of efficient extraction of pertinent information. This is like two machines interacting, and since we are not machines, it produces harm. The patient feels diminished, as though they are a means to an end (diagnosis). The physician misses out on the rewards of making an emotional connection with another and the opportunity to reduce their suffering (as opposed to their pain).

You're right that it is not one way or another, but a balance between efficiency and listening. In fact, I believe that skillful listening improves efficiency, as well as reduces physician frustration and burnout. When you've created the conditions in which your patient is your partner, you've taken steps to ease your own burden as well as theirs.

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

The mom seems as though she could benefit from some parenting skills. Alex sounds like a normal, energetic 3 yr old, but mom is, understandably, overwhelmed between her daughter's constant motion and her one year old, and perhaps other stressors as well.

Comment #2

This is an excellent comment, Amanda. You can always learn a great deal from your patient, no matter whether they are a rambunctious child or a stroke patient or a patient with cognitive impairment. Having another source of information is always valuable, but you never want to overlook the patient just because it is easier to talk to someone else.

Comment #3

I think when you are clear about your need for firmness/directness, you will be more comfortable taking a strong stand that is still kind and caring.

Comment #4

This is very impressive. Many experienced physicians have no idea what they're feeling, yet these feelings definitely can intrude into the patient encounter and influence it in undesirable directions.

Comment #5

You did an excellent job of extracting lots of learning points from this encounter. You realized how valuable it is to always pay attention to your patient, no matter how difficult this might be; the importance of knowing how to set firm boundaries with patients, while maintaining a caring, kind attitude; the value of paying attention to your feelings so that they don't influence the encounter in negative directions; and how essential it is to invest extra effort in developing a connection with patients in an interpreted interview. This was a very insightful and thoughtful essay!

Comment #1

If you haven't encountered this problem previously, you certainly will again in the future. The challenge of clear communication among teams is a significant one. When it works, patients feel confident they are getting optimal care. When it doesn't, they feel anxious, confused, and mistrustful. Communication and coordination take time, but they are well worth the effort.

Comment #2

It's interesting that in both of your examples, the patient misinterpreted the intent of the team. In the first example, the teams were actually coordinating; in the second example, discharge was actually not going to happen till the patient was ready. But because of poor communication, the patient felt her teams weren't talking to each other and that she was being pushed out of the hospital.

Comment #3

Your essay highlights the importance of choosing words wisely, so that they convey what the speaker intends. Anticipating and addressing patient confusion in the face of multiple team interactions with a proactive statement can head off problems down the road: "We know there are

multiple teams involved and we know this can be confusing. These teams are here to make sure we don't miss anything and deal with all your symptoms. We want you to know we are talking regularly with each other to put together the pieces. If you ever feel we are sending you mixed messages, please let us know."

In terms of communication generally, it is worth pausing a moment before making an important communication to ask yourself, how is the patient going to here this? Am I being clear? Could what I have to say be misinterpreted? Again, collecting one's thoughts before speaking takes a little extra time but pays great dividends in patients who are on the same page as their doctors and who are on board with the treatment plan.

Comment #1

These situations are all too common, are incredibly frustrating, and remind us in very painful ways of the unavoidable intersection of structural injustice and patient wellbeing.

Comment #2

And right away we find ourselves in a tiered system of healthcare, where those with resources can afford top-flight medicine and those without, go without.

Comment #3

It is admirable that the healthcare providers and the clinic address and attempt to resolve these barriers. It is worth asking whether, with a more equitable system of healthcare, doctors would even have to expend time and energy looking for such piecemeal solutions.\

Comment #4

I agree with you that FQHCs play a critical role in filling a gap in our healthcare system. Often the care is "equally effective" thanks to the dedication and commitment of individual physicians and healthcare staff, but sometimes it is not. It is worth considering how we might achieve more just and fair approaches in a more systematic way.

Comment #5

Thank you for your essay. You are absolutely right that the structural and social determinant aspects of clinical medicine are insufficiently covered in the curriculum, although I believe that is changing. The reality is that, for many in our country, these considerations are inextricably interwoven with the decisions they make about when and how to seek care and the extent to which they can follow physician recommendations.

It is wonderful that individual physicians and clinics such as FHC-SA step in to compensate for the healthcare system's overall shortcomings, but it is important to ask ourselves whether our country needs more comprehensive solutions.

Comment #1

You were very observant of these patient, and had significant insight into how his social history may have interacted with his symptoms.

Comment #2

I think you likely deserve some credit for creating a space in which the patient felt safe enough and comfortable enough to disclose some of his fears and concerns.

Comment #3

Of course, this is a common reluctance among many patients, from many cultural, social, and economic backgrounds. Perhaps we can discuss further "baby steps" that might lay the groundwork for a such a radical (to the patient) idea as counseling.

Comment #4

So you discovered that you both shared similarities and had considerable differences with the patient. Knowing this can help ensure that you can use the commonalities to advance his wellbeing and be on guard that your different perspectives (such as doing something for your benefit regardless of social consequences) do not result in negative judgments that might discourage the patient.

Comment #5

You should feel proud that you were able to win your patient's trust so that he could disclose some of his vulnerabilities, thus laying the groundwork for a future relationship (if you were actually his physician). Your honest introspection also revealed areas that, without awareness, might complicate care of the patient, such as the patient's fear of intellectual inferiority to physicians, his resentment of being judged or condescended to, and your assumption that, if someone knows something will benefit them, they will always pursue it, regardless of the opinions or evaluations of others. These differences could easily influence the doctor-patient relationship in negative directions, but by bringing them to light, you can anticipate how they might affect your interactions with the patient and take steps to mitigate any ill consequences.

Comment #1

It's interesting, and somewhat worrisome, that the larger illness context seemed to have disappeared at least in the notes, with the focus restricted to treating the patient symtomatically.

Comment #2

I love that you followed up in this way. What a great question to help you understand the lived experience of the patient - at least a little bit.

Comment #3

This is absolutely true and I think relieving his seborrheic dermatitis or his hemorrhoids might actually improve his quality of life a bit, although they are minor problems. It's not a bad thing to be able to take simple actions that can alleviate discomfort. The only question I'd have is why hasn't he been able to establish a continuity care relationship with a physician? Why is he bouncing around so much? This is the kind of patient that calls out for a reliable family physician (as well as a neurologist if possible). In a continuity relationship, in addition to addressing episodic concerns, this doctor could occasionally visit the larger picture: Does the patient have a plan, hopes, expectations as his condition worsens?

Comment #4

Thank you for such an excellent choice of patient to write about. People with disabilities obviously also need primary care, yet the healthcare they receive is often inadequate. I appreciated the way you connected with the patient on a human level, this is the only way to develop a relationship that will endure over time and help keep the patient coming back to you. This patient really needs a physician he can rely on, who can get to know him, and figure out how best to address his multiple healthcare needs. I also think there are larger issues, such as what will happen to this patient long-term, that need to be addressed, but that cannot be broached in an episodic visit. I respected that you thought about this patient, worried about him, and were sensitive to the larger context. That's what a good family doc should be doing.

Comment #1

It is so frustrating time and again to see patients receiving inadequate treatment because of inadequacies in the healthcare system. This leads to negative physical and emotional outcomes for patients, and moral injury for physicians.

Comment #2

You are absolutely right to identify social determinants contributing to this patient's disease. His limited resources (including perhaps restricted health literacy, poor insurance, low wages, priorities of paying rent, keeping his job rather than personal health) all disadvantage him in the healthcare market. His odds of being able to effectively manage his diabetes are lowered because of structure inequities over which he has little control.

Comment #3

the situation you describe occurs in a physician's office where the individual doctor and patient are expected to work out a solution. However, as you astutely recognize, solutions are more likely to be found at the systemic level. With universal healthcare, for example, the patient would increase his chances of receiving appropriate medication. In a society that recompensed him fairly for his work, he might have more disposable resources to support a focus on personal health. In a just society, he would always be treated as someone of value, and would not be dismissed because of the color of his skin. Your example helps us see that while healthcare seems like an individual transaction between two people, it is inextricably entwined with larger social forces that must be addressed to support both patients and doctors.

Comment #1

I've heard similar comments from other Latinx patients - and patients from many other cultural backgrounds (white, Asian, South Asian, Black). The stigma of mental illness sadly is widespread, although it takes somewhat different forms depending on many cultural, structural, and individual factors.

Comment #2

This attitude may represent effects of the intersection of traditional sex-typed roles and expectations and culturally mediated mental illness stigma.

Comment #3

Faith can be both a plus and a minus in a patient's reaction to illness. If faith is something to lean on, it augments treatment and can be a source of strength. If the patient feels "faith alone can heal," it may deprive them of much-needed medical intervention.

Comment #4

I appreciated your sensitivity to the overall context of this patient's symptoms and diagnosis. You understood well how issues of stigma and traditional wife/mother roles could act against her seeking needed treatment. I also liked that you considered how her religious faith might influence her attitudes toward psychiatric help.

Then you went above and beyond by mining your own experience for what could help you understand and empathize with the patient's situation. This can be both invaluable and treacherous. Of course, your experience is not the same as your patient's, so we have to be careful not to make assumptions about what we know about the patient. On the other hand, there may well be overlaps or points of similarity that can provide deeper insight.

Finally, kudos to you and the team for creating a safe supportive environment where a patient who had never before spoken about her feelings was able to share authentically and openly. It is even possible that this saved her life.

Comment #1

Language and cultural differences can present challenging barriers to expressing understanding and support, even when the provider might be feeling them.

Comment #2

Interesting awareness - I'd like to hear more about how you phrased the questions and how you might have modified them.

Comment #1

I've heard similar sentiments from other first-gen students. While we never want to project our experiences onto others, and there are certainly many differences in the immigrant experience, there are also similarities that can create bonds and deepen understanding.

Comment #2

This is the sort of statement that asks for further explanation, yes? When patients "forget" a major medical issue, there are often factors of finance, lack of insurance, undocumented status, skepticism of the healthcare system etc. in play.

Comment #3

Yes it's important to be aware of how sensitive these topics can be, and be able to create a safe space for patients so they can be forthcoming as possible.

Comment #4

Residents and attendings at FHC-SA are used to go the extra mile for their patients. It is an incredibly admirable quality. At the same time, we should recognize the structural inequities that require these superhuman efforts on the part of individual physicians; and consider how we can repair the system's deficiencies.

Comment #5

Thank you for this excellent essay. It illustrates very well the inevitable intertwining of culture, class, undocumented status and healthcare. There is no way we can pretend medicine exists in an "objective," "neutral" realm where doctors just deliver care equally to all who pass through their doors. It takes some skill to work your way through these barriers to earn patients' trust and begin to try to really address their problems. As you saw, dedicated physicians can make a big difference. However, ultimately the answer lies in systemic reform. It's important to pursue both paths simultaneously: work to help individual patients as much as possible; and do what you can to push the healthcare system in a more just direction. I'd also be curious to hear more about how your own background might help you connect with or understand something about this patient.

Comment #1

How can you acknowledge the patient's displeasure? "I know some people worry that they're 'just' getting a medical student. That makes sense to me. Can I explain why it actually helps the doctor?"

Comment #2

Were you able to understand why this might be? Did she worry you would be judgmental? Unskilled?

Comment #3

In my view, you learned EXACTLY the right lesson from this encounter. You cannot help people medically until you've heard their concerns and have gained their trust. The protocols and algorithms on which medicine are based are of course useful and necessary, but they overlook the "art" that is involved in just listening to people and seeing them in all their complexity (including their sometimes

bad behavior). This perspective does not excuse the patient's unpleasantness to you initially; but hopefully in the future will trigger curiosity about what underlies that behavior. That is when you can dig down and find some real solutions. Nice work!

Comment #1

Your essay raises several interesting issues. First is the patient phenomenon of doctor-shopping and the best way to interact with a patient who is seeking a very specific treatment. How can you empathize with their distress while diffusing their tunnel vision about appropriate treatment? Second is a systemic issue that provides monetary incentives for procedures and surgeries over ore conservative management. This can lead to an unfortunate interaction between a patient convinced that surgery is the best (because the most expensive and dramatic intervention) and a surgeon who knows that they are incentivized to perform surgeries. The outcome, of course, is more potentially unnecessary surgeries.

Comment #1

Great question - this is the heart of the matter. The patient is at some risk, yet she refuses treatment that might protect her. How can you try to resolve this dilemma?

Comment #2

Very well done. You persisted in conveying your perspective, but respectfully and without negative judgment. You looked for solutions that honored her preferred method of treatment, listened to her point of view, and proposed a course of action that integrated both approaches. The effectiveness of your interaction is found in the patient's agreeing to your proposed pan.

Comment #3

This is an excellent example of how to effectively reconcile the "voice" of the physician and the "voice" of the patient. Key is the respect and lack of judgment you and your attending conveyed in discussing her options. Rather than attempt to impose your will, you listened to your patient's perspective, showed empathy, and eventually proposed a path forward that both honored your concerns for the patient and her own beliefs and expectations. This approach exemplifies how it is possible to bring very divergent views closer together.

Comment #1

You know, sometimes in these situations there is a point of no return, where the patient crosses a certain threshold and rather than engage, it's sometimes better to politely excuse yourself and offer to come back when the patient is calm enough to have a conversation with you.

Comment #2

Absolutely, this is very insightful. Just as patient gratitude sustains and uplifts physicians, harsh attacks can be extremely demoralizing.

Comment #3

Yes, frustration is a normal human response when you are trying to help someone, and they resist that help. An interesting question becomes, what can you do with that frustration that is constructive, that doesn't harm yourself and perhaps helps the patient?

Comment #4

you've written a really honest and interesting essay. There is no question that patient ingratitude and bad behavior is a contributory factor to physician burn-out. Yet, while you can hope that all patients respond with gratitude and appreciation, you are not able to control patient behavior. So what to do? A wise lesson, which I'm sure you've heard before, is to not take such behavior personally. Of course, it is always valuable to seriously consider a patient's feedback and ask yourself - have I been uncaring or dismissive toward this patient? If the answer is no, then you realize this is not about you.So what is it about? Underneath a lot of anger is fear and hurt. Maybe this patient is frightened of going home (after all, he almost died). Maybe there is no one who cares about him. Maybe it's something else. Trying to penetrate into a patient's distress can be helpful in addressing the underlying issue.Often I've had the sense that when a patient tells a doctor, "you don't care about me," it is a kind of test. The patient is waiting to see how the doctor responds. Will the doctor leave in anger or emotionally withdraw from the patient? Sometimes by simply staying the course and calmly and kindly continuing to interact with the patient, they realize that, after all, you really are on their side.Finally, it is completely within the bounds of professionalism and good doctoring to set limits on a patient's behavior. You can stay committed to your patient and continue to feel compassion for their suffering while letting them know that certain ways of speaking and acting are not acceptable. You will always be there for your patient, but just as you try to treat him courteously and with respect, you expect the same from him. I look forward to discussing this case with you. It's a situation that arises all the time, and learning how to deal with it will help you avoid burn-out down the road - as well as improve the relationship with the patient!

Comment #1

What does this even mean? To me, it sounds like the end of a conversation, rather than the beginning. It sounds like an excuse, rather than a solution.It almost sounds like blaming the patient for being Korean, rather than blaming the healthcare system for being full of holes.

Comment #2

Very well put, Ava. Unfortunately, this is exactly the case. Here was a person in need. If he hadn't fortunately recovered, he would have been shunted aside by our healthcare system. Because of his lack of resources, it was easy to dismiss him and not involve him in shared decision-making in any kind of meaningful way.

Comment #3

I agree with you this is an extremely troubling encounter, which exposes the shortcomings of the American healthcare system (as well as its racism). I agree entirely that, if the patient had not luckily improved, sending him home alone would have been a very inadequate solution. Most people in this situation would have felt moral distress because they would sense what should happen, but couldn't figure out how to make this a reality. The resident who talked about "cultural differences" was not a monster. They probably felt helpless and inadequate themselves; but not knowing what to do with their feelings, tried to move on with a simplistic explanation that let them - and the system - off the hook. At the very least, until we have a more generous and equitable healthcare system in this country, we should try not to compound its injustices by blaming the patient for his culture; or coming up with unrealistic discharge plans. I wonder whether there would not be Korean community organizations or perhaps a church that could have provided interim support. Unfortunately, there was little incentive to solve the patient's dilemma because it was easier to dismiss him as someone who didn't really matter.

Comment #1

That is such an interesting insight, Axana. I suspect that is true for anyone for whom English is a second language, no matter how fluent and "bilingual" they are, yes?

Comment #2

Good observation. Patients are often more comfortable disclosing health concerns when you've established some kind of personal connection.

Comment #3

Such a wonderful sentiment. Being able to love every patient in some sense or other is what makes an outstanding physician.

Comment #4

Your attitudes of flexibility and openness are much needed qualities for practicing medicine in a culturally diverse context. Your background and experiences have prepared you well to be comfortable entering patients' worlds, whatever they may be. I was also touched by your sensitive, gentle approach to the patient you describe. What you were doing is 1) not taking her desire for the "attending" personally but rather working through her concerns 2) taking the time to get to know her as a person, which builds trust and has many benefits down the road in terms of patient adherence and health outcomes. I agree, you are where you are meant to be!

Comment #1

I also endorse the relaxation/stress reduction techniques you recommended to the patient. At the same time, it is important to keep in mind that some devout Christians, especially certain evangelical sects, have a great mistrust of yoga/meditation as "ungodly." So it always helps to keep in mind that what most people regard as a "neutral" stress reduction strategy can be perceived differently by patients from other backgrounds.

Comment# 2

I have often run across patients who use prayer much as others use meditation - i.e., as a way of calming the mind and spirit; and, in their case, turning over problems to God for help. Some patients are more comfortable engaging in prayer than in meditation, so it can be important to clarify the patient's views. Many are comfortable doing both. However, keep in mind that originally meditation emerged from a nontheistic religion, Buddhism, and some people of faith are suspicious of the practice. On the whole, it is usually beneficial, as you did, to find what people are already doing that might be enlisted in the service of stress reduction as well as suggesting what may be novel approaches.I've never heard of early dinners reducing stress, but it may be that honoring a family tradition is a relaxing practice and, just as you did, should be encouraged to continue.

Comment #1

I think this is an accurate observation. The challenge is to build gates in these walls where both doctor and patient can pass through.

Comment #2

Yes, I agree that unfortunately, language difference can restrict comfort with personal disclosure.

Comment #3

Indeed, when both doctor and patient feel the other is trying to communicate, it becomes a self-reinforcing positive loop.

Comment #4

Well said, Brenda. Your use of the patient's language is not only the employment of words in Spanish, but also signals that you respect the patient and are willing to communicate with her in her own language.

Comment #1

Excellent observation, Brian. Language differences are only part of the challenge. Cultural differences in expectations and assumptions also complicate the doctor's task as you astutely observe.

Comment #2

Excellent analysis. You and the patient had different agendas. Both are valid, but it's the physician's task (or the medical student's) to reconcile these differing agendas in such a way that the patient feels seen and heard.

Comment #3

Very thoughtful analysis. Your reflection on this interaction is a model for how we can learn and grow from situations where we sense we could have done better.

Comment #4

This is an impressive reflection in several respects: 1)You recognize that cultural as well as linguistic differences can complicate the patient interaction 2) You realize that you and your patient had different expectations and agendas 3) You reflected on the incident non-defensively and insightfully so that you were able to identify specific and concrete ways in which you could effectively modify your approach in subsequent similar encounters. As you say, by eliciting the patient's needs and addressing them respectfully and seriously by incorporating them into your treatment plan; and by building trust and rapport, you can deliver good care even across language and culture.

Comment #1

It can be very hard for physicians to understand patients whose health is not their highest priority. In fact, a lot of people put many other things ahead of their health.

Comment #2

It sounds like you were working harder than the patient to save his eyes. It is natural to want to distance from the patient when they seem to be distancing from themselves.

Comment #3

I think in this situation, many doctors would be asking themselves, is there anything I could have done differently to encourage patient adherence to this very complex regimen? It's hard to answer that question. Sometimes, in fact, you've tried everything, and are still not able to overcome the patient's denial, or cognitive disorganization, or structural factors that work against follow-through. In this case, I'm left wondering about many things as well (and will probably continue to think about this patient, as are you!). Might a motivational interviewing approach have been useful? What was at the root of the patient's nonchalant attitude? Did he disbelieve or not grasp the severity of his condition? Did he lack the skills necessary to commit to the treatment plan? Did he prioritize work over his health? Empathizing with the enormity of what you're asking the patient to do can lead to realistic problem-solving (i.e., anticipating obstacles, getting someone to assist in the implementation). Teach-back is another potential way of getting patient buy-in. Bottom-line, you are looking for some way to get the patient to make a proactive commitment to their health. But as above, there are no guarantees that any approach will be effective. In the end, you want to feel you tried all the strategies at your disposal. Then you might not need to think about them every week.

Comment #1

Cecelia, this is very honest of you and also correct. So you can't establish a relationship based on shared history, background, or understanding. Instead, you must start with incomprehension. That is not easy, but it is an authentic starting point.

Comment #2

Your essay shows a lot of care about your patient, as well as understanding of the structural and societal racism that may well have contributed to his current state. The way I read your essay, your main concern was your difficulty in connecting with your patient because you could not find common ground. I appreciate your acknowledgment of this reality. Differences in community, cultural, racial, historical and societal reference points could make it harder to relate. But harder is not the same as possible. I admire that you persisted in talking with him, and that you indeed made a little progress. With more time, you might have earned his trust and convinced him that, indeed, you were there to care for him and advocate for him. Listening to his story with respect and interest was a very good first step.

Comment #1

Good for you. In this case, your goals may be a little differently prioritized. For example, whereas with another patient, the goal of obtaining a detailed history, is prioritized equally to establishing a connection and demonstrating respect and caring, with this patient the latter may be more important, while relying on the sister for the former.

Comment #2

Good insight on your part in terms of how the medical information you provided was affecting the patient emotionally. What from a medical perspective can seem minor and routine can often be frightening and confusing to the patient and family.

Comment #3

This is an excellent idea. We think of such conversations around serious diagnoses and end of life issues, but in fact they can be very useful to have at any point in care. Also, given the patient's developmental delay, you could have considered asking the sister for ideas about how to present information in the most digestible way to the patient (I would NOT however advise the sister being the decision-maker for what the patient is or is not told, unless she legally has this power)

Comment #4

I admire your sensitivity to this patient, and especially your awareness that you and the resident may inadvertently overloaded her and her sister with what, from your perspective, seemed like routine and not alarming information. Your insight that what seems "minor" from a medical point of view, can be really scary and confusing to the patient. Most impressively, once you sensed that the patient and sister were struggling, you both adapted your behavior to support them. Small things, such as opening the door, walking the patient out can be extremely reassuring and show you actually care. Adjusting the flow of information into bite-sized bits was also an excellent idea to alleviate the

patient's anxiety. It's really heartening to see your awareness of how much was going on in this seemingly simple encounter, and all that you did to move the interaction in a more positive, patient-centered direction.

Comment #1

This seems pretty sad and frustrating. It is really hard to interrupt someone and get them to talk about something else without them feeling cut off and overlooked. I wonder if there might be ways that express respect and support.

Comment #2

Exactly - so the importance of establishing priorities: What is the most important thing that needs to be addressed? This can be a negotiation between patient and physician, so that the patient does not feel excluded from her own healthcare.

Comment #3

You clearly learned some really important lessons from this encounter and from watching and then debriefing with your resident. In terms of redirecting tangential conversation, I'd like to offer a few additional thoughts:1) When you realize the patient is not "on point," and time is passing, it's easy and understandable to become frustrated. This frustration and irritation can seep into the interaction, and therefore the patient can feel judged or blame. So it's important to take a breath and stay calm. 2) Whenever possible, instead of actively interrupting, look for that pause when the patient has to take a breath (everybody needs to :-)), and then gently insert a positive but redirecting statement. 3) Acknowledge the value of the patient's off-track story ("This is such an interesting story, I wish we had more time to talk further about it. Right now I want to make sure we address the problem you're most worried about, which you told me is your back pain"; "I know this symptom is upsetting, let's make another appointment to discuss it further. For now, let's get back to your most important problem..."When you combine these with more closed-ended, focused questions and setting priorities, you can usually conduct an efficient interview without alienating your patient!

Comment #1

This is a good example of empathy, imagining the experience of the other. While we can never really understand another person's experience, this imaginative exercise can help improve your grasp of the patient's situation and is really important.

Comment #2

Yes, I often hear similar comments from first-gen students. There are a lot of differences between immigrant and first-gen experiences, and between immigrant experiences in general, but being close to one such experience often provides ways of moving closer to others' experiences.

Comment #3

Excellent conclusion. Finding common ground, no matter how seemingly difficult, is essential in establishing trust, and therefore good medical care.

Comment #4

Thank you for a thoughtful essay. I agree with you that while there are many differences in immigrant experiences, being "close" to this experience can help you find common ground with your patients if you approach them with humility, genuine curiosity, and respect.I also like what you say about the importance of finding common ground, not only in terms of culture but also in terms of political or religious beliefs. We are a very divided country now, and as individual humans, there are some people that we empathize with and want to help; and others whom we might actually find repugnant, close-minded, ignorant etc. It is in these latter situations that, without compromising your values, you are able to reassure patients that you will provide them with care and help.

Comment #1

These are very good questions. Especially when working across language and culture, it is important to find the proper balance between not minimizing concerns while not excessively frightening the patient. The first step in doing so is to ensure adequate translation services.

Comment #2

Exactly the right conclusion in my book. Three years ago the patient, with fairly small adjustments, could take charge of her health. Three years on, this goal may be much harder.

Comment #3

I like the way you tie the steps needed to ensure patient wellbeing to physician burn-out and stress. These are precisely the sorts of physician-related issues that can interfere with optimal patient care.

Comment #4

I love your concluding line: "Our patients deserve that we try for them." So true. I think you also do an excellent job of thinking about what gets in the way of doing so. Sometimes it is a clinic protocol implemented for efficiency rather than optimal patient care. Sometimes, as you suggest, it is burn-out and stress in the physician. Sometimes it is lack of interpreter resources. Regardless, none of

these excuses neglect of patient wellbeing.Further, I appreciate your emphasis on prevention. I think you are absolutely right that the time to intervene with patients is before they tip over in active disease. In this case, there are indications that, three years ago, the patient was at risk for a variety of lifestyle diseases. How much easier to begin working on lifestyle modification in a "thoughtful" manner than waiting until she had reached a crisis point.

Comment #1

I agree that the capacity to remain calm and focused is essential in medicine, when so much intense emotion and uncertainty is often swirling around you. What I find particularly notable in your attending is that she apparently was able to remain composed without being detached - indeed, she spent considerable time talking with the patient. This shows that calmness and compassion can go hand in hand.Another valuable skill which may or may not have been relevant in this particular situation is the ability to confront "bad behavior" directly, with curiosity and kindness. I wonder what might have been learned if the attending had said to her patient, "You seem really angry with me. Can we talk about it?" Showing your patient that you're not afraid to tackle even very hard topics with them can puncture hostility and also reassure them that you are committed to their care even in the face of disagreement or conflict.

Comment #1

Yes, usually in these circumstances you could use both the daughter and her caregiver mother as sources of information, but once you lost the interpreter function, the daughter became the sole reporter. Normally, of course, this would be entirely appropriate, but because of her intellectual disability, you are right to be concerned.

Comment #2

It sounds to me as though you did a good job of working with her and trying to assess to what extent she was capable of giving you the information you needed.

Comment #3

Yes, I think what you're getting at is that changing people's deeply rooted familial and cultural practices is not easy and needs to be approached with tact and humility. Often, altering food preparation in ways that are culturally sensitive are most successful.

Comment #4

I think sharing this empathic awareness can help build rapport with the patient and let her know that you understand the difficulty of the task she's facing.

Comment #5

You make some very interesting points. One is to what extent is a person with intellectual disability or cognitive impairment is able to be an active participant in their own healthcare. The answer is, it depends! I liked that you soldiered on with your patient, and hopefully began to get the scope of her capacity, where she could meaningfully participate and where the mother's input would be needed.The other question of importance is how to intervene with patients to encourage them to modify culturally based patterns of food preparation and consumption. This, as you realize, is not an easy undertaking. It is usually more successful if it involves not just the individual, but at least the entire family and ideally is a shared project of neighbors/friends/patients from the local community. Often prometadoras (members of the community trained in diabetes counseling) can act as an effective bridge to find ways of making healthy changes that make sense to the patient and are compatible with their overall life.Finally, your awareness that your own cultural background shares something in common with your patient offers a great opportunity to establish a connection. Sometimes shedding the white coat and sharing a personal detail can build trust with the patient and convince them that you truly do understand how difficult it will be to make the necessary changes.

Comment #1

Yes, I've also seen several engineering patients, and I recognize this meticulous monitoring and record-keeping!

Comment #2

Please note that what I'm about to say is not meant as a critique of this particular attending. Obviously in a short essay you can't put in all the details; and I'm sure the attending had his perspective as well.That said, it's important to do your best to, within limits, adjust your style to that of your patient. This patient does sound a little OCD but as long as that is more a personality inclination than a diagnosis, it's respectful to be guided by his concerns. Ask yourself, what does this patient really want? Probably he wants reassurance that he is receiving optimal care. Discrepancies (such as the scale) are unnerving to him. Taking the time to explain that there can be variations due to clothes worn, time of day, different day and that these do not impair your ability to determine his health status might help. Similarly, a question about drug brand shows that the patient wants to be actively involved in the management of his health and make sure he is getting appropriate treatment. He is NOT questioning the physician's competence.As you tell the story, the physician, rather than encouraging this engagement, shut down the patient. The phrase "deal with him" is especially demeaning because it implies that the patient is being "difficult" or causing trouble. I really do not see evidence of that. This response is hierarchical, patronizing and uses the physician's power to

control the interview rather than being responsive to the patient's needs and concerns.Putting such a disrespectful note on a chart to me is also unprofessional and inappropriate. It prejudices all future nurses and doctors who will care for this patient. It is stereotyping and derogatory and could negatively affect this patient's healthcare.It's important to ask yourself, what motivated this physician to behave in such a manner? Is he burned out? Depressed? Angry? What steps can you take to ensure that you do not become this doctor? I wonder if you considered saying anything to him about the exchange, even asking an "innocent" question such as "Hmm, what do you think others should watch out for?" I recognize how difficult it is to challenge an attending, even respectfully, and I wonder if this is the type of issue that you could bring to the attention of the clerkship director. Although you did not say so directly, I think you recognized that this was not appropriate behavior. I hope you will continue to trust your instincts where the humanity of the patient is involved.

Comment #1

You've written a really honest and interesting essay. There is no question that patient ingratitude and bad behavior is a contributory factor to physician burn-out. Yet, while you can hope that all patients respond with gratitude and appreciation, you are not able to control patient behavior. So what to do? A wise lesson, which I'm sure you've heard before, is to not take such behavior personally. Of course, it is always valuable to seriously consider a patient's feedback and ask yourself - have I been uncaring or dismissive toward this patient? If the answer is no, then you realize this is not about you.So what is it about? Underneath a lot of anger is fear and hurt. Maybe this patient is frightened of going home (after all, he almost died). Maybe there is no one who cares about him. Maybe it's something else. Trying to penetrate into a patient's distress can be helpful in addressing the underlying issue.Often I've had the sense that when a patient tells a doctor, "you don't care about me," it is a kind of test. The patient is waiting to see how the doctor responds. Will the doctor leave in anger or emotionally withdraw from the patient? Sometimes by simply staying the course and calmly and kindly continuing to interact with the patient, they realize that, after all, you really are on their side.Finally, it is completely within the bounds of professionalism and good doctoring to set limits on a patient's behavior. You can stay committed to your patient and continue to feel compassion for their suffering while letting them know that certain ways of speaking and acting are not acceptable. You will always be there for your patient, but just as you try to treat him courteously and with respect, you expect the same from him.I look forward to discussing this case with you. It's a situation that arises all the time, and learning how to deal with it will help you avoid burn-out down the road - as well as improve the relationship with the patient!

Comment #1

This is indeed an unusual and troubling response. What do you think lay behind her attitude?

Comment #2

Indeed. You are seeing these patients in a cross-sectional, usually single encounter; whereas they and their diseases are (ideally) being treated in a longitudinal way that addresses some of the root issues that are activated.

Comment #3

I too am struck by your patient's response. It is truly hard to understand.In your essay uou are trying to figure out how to remedy the patient's "deficit" - ie., her lack of appropriate response to a dangerous yet remediable medical condition. But I suspect we don't really know what that "deficit" is yet (perhaps her physician with whom she has such a strong relationship does).What has made her so fatalistic? Has she seen someone close to her lose a leg to diabetes? Is she trying to "control" a negative outcome by anticipating it - "Oh, you're telling me I'm going to lose my leg? I already knew that." It is even possible, though highly unlikely, that her apathy is due to a psychiatric condition that makes her indifferent to her disease.In any case, until you better understand the source of this remark, it is hard to figure out exactly how to work constructively with the patient's attitude. But it is definitely worth further investigating. ("That's a curious thing to say. Can you tell me more about what you're thinking?") Once you have a better sense of the patient's logic (which does exist), it is usually possible to find a path forward.

Comment #1

You know, presumably he consented to the procedure, so exercised his autonomy in making this decision. I think now he may not be saying so much that he literally wanted to die of cancer, but rather that he's crying out for help in figuring out a more manageable way of living.

Comment #2

It sounds like the patient was struggling with his colostomy and was seriously depressed (understandably). He was projecting that anger on his doctors, which of course is not appropriate, but again, he is just looking for someone to blame for how hard his life has become.

Comment #3

I applaud your point that patients need to be prepared for the emotional and psychological sequelae of major surgical procedures and medical interventions. This particular patient sounds like he is really suffering, which is totally understandable. Because life with a colostomy can be really tough, there are support groups available, and the patient might benefit from participation in one. But even

better would have been advance preparation as you suggest to head off some of the intensity of his feelings. I'd be curious to know how the surgeons responded to his outburst. Right now this is a cry from the patient's heart and he needs to be heard not defensively or in a blaming response, but with compassion and caring. He needs hope that there is a way through this.

Comment #1

Your goal is to assess the patient and find out what happened to the daughter. The patient's goal is to find someone she can entrust her story to. By taking the time to build rapport you showed her you were willing to be that person.

Comment #2

Human beings all feel similar emotions, but they are filtered through personality, family, and culture, which can make them hard to interpret in different contexts.

Comment #3

Very well said. Treatment, especially for psychiatric disorders, is not one size fits all. Your awareness of the patient's extreme difficulty in sharing any of her past pain would be essential in determining your treatment approach.

Comment #1

It is always a good idea to remain calm in the face of a patient's anger, rather than escalating the conflict. But remaining calm is just the necessary first condition for engaging the patient to better understand their distress, which is what ideally should happen between doctor and patient.

Comment #2

I wonder what the doctor's feelings were that he was "ignoring." It can be pretty hard to ignore our feelings; and then they can leak out into interactions in ways we are always aware of.

Comment #3

How to handle an angry, noncompliant patient is an interesting and complicated question. From my perspective, staying calm is an essential first step. It's very easy to match the patient's emotions, to meet anger with anger. but this just makes matters worse. With this patient, I would have many questions. What are they so angry about? What is making them so afraid? Is there anything to be done to make them feel more cared about? Sticking to the medical aspects may make the interaction simpler - certainly shorter - but it may be missing some of the patient's important needs.

Comment #1

It's always good to respect the patient's wishes. On the other hand, since it is part of the patient's care that you are there, you are entitled to explore this further. You might probe one step further: "Of course you don't have to answer my question, but can you help me understand the reason?"

Comment #2

I think it's great to ask, might I have done something to contribute to the patient's response? But you don't have to do this in a blaming way. Rather, it's an opportunity for learning. Sometimes we did do something that we can improve on. Often, however, the patient's reaction has nothing to do with us and everything to do with other life circumstances.

Comment #3

As above, this is often the case. Still, sometimes (not always) by not being intimidated and in a nonthreatening, friendly way staying the course, you can sometimes win over the patient.

Comment #4

I'm sorry you had this upsetting encounter. From what you describe, I very much doubt you even had the opportunity to do anything that might have offended your patient! As you say, people may be having a bad day or a bad life, which does not excuse rudeness, but it helps us understand it.It is always important to honor patients' wishes when possible, because they have already lost many degrees of control and autonomy because of their illness. So simply acceding to this patient's request was a good way of handling the situation. Sometimes you can go another round, by saying gently and kindly, "I hear you want me to leave and I will. Before I go, can you help me understand if I've done anything to upset you or if there's anything I can do to help and support you?" Or sometimes you can say, "The doctor is with another patient, and as soon as she's free she'll be here. Would you mind if I just hung out for a few minutes. I don't have to ask you questions but I'd love to learn something about you."It's really a judgment call, and you never want going or staying to be a power struggle between you and the patient.

Comment #1

It sounds to me like you handled this situation very well. You helped her see that she was getting "extra" care, not from a student only, but from a student PLUS the doctor. Reframing things in this way can help patients better understand how care in an academic medical center is delivered.

Comment #2

Wow, this must have been overwhelming to hear. Yet what strikes me is how you must have established a strong relationship with the patient in order for her to speak so openly with you about her distrust of the medical system.

Comment #3

This seems like an excellent response. Something else to consider is to thank the patient for their honesty, so they know you're not upset to hear their skepticism about your profession. You can also ask them to be sure to tell you any time they have a concern about your recommendations or the care you're providing. Keep the issue of trust directly on the table and signal the patient you're not afraid to deal with this in the encounter.

Comment #4

Very perceptive on your part. The patient undoubtedly has lots of strong feelings that may manifest in the encounter, so it's important to be aware of this, as you obviously are.

Comment #5

I admire your resolve, and find this particular question especially skillful. It communicates directly that you want to serve this patient well and you want their input to guide you. Lovely!

Comment #6

this is an extremely perceptive and insightful essay. You demonstrated impressive critical analysis of the specific challenges in this encounter and how they might be addressed. You also showed a lot of empathy for the patient's angry, mistrustful reaction, which can be hard to do.Your awareness that patients in under resourced communities often worry they are getting second-class is important in helping to craft a nondefensive, supportive and reassuring response. It seemed to me that you must have done an excellent job of establishing rapport with the patient for her to be so forthcoming about all her hesitations about the healthcare system. You were also very aware of how to de-escalate rather than inflame this situation. I've found that when patients express reservations about their healthcare, it helps to acknowledge their fears overtly and reassure them that you want to work with them so that they feel they're receiving the best care possible.Finally, your empathy for the fact that the patient had just lost her father and how her emotions might affect the encounter was also perceptive. The patient may be feeling sorrow, grief, fear, guilt, loss, anger - a whole host of intense feelings that she may express in her interaction with her doctor simply because she cannot contain them. By realizing what's going on with the patient, you can avoid taking these expressions personally and instead be able to support the patient compassionately. I loved your last line. If more doctors would ask this of their patients, there would be a much better sense of mutuality and teamwork in the doctor-patient relationship.

Comment #1

Clearly there is some denial going on here, there is something heroic about the fact this man is "still laughing, still living."

Comment #2

I'm sad to learn the patient succumbed to his disease. I think you derived exactly the right lesson from his death. As physicians, you literally do have people's lives in your hands, and sometimes you can't save them. And it is painful when you reach the limits of medicine. This is really where we discover "the humanity that hangs in the balance." As you so compassionately realize, this man loved and was loved, and sought not only treatment but care.

Comment #3

I can see how moved you were by your encounter with this patient and by his death. In my view, the lessons you received from the patient are what lies at the heart of medicine. First, one of the most important realizations for physicians is to learn how to accept the limitations of medicine. While it is good to fight against them, knowing how to also let go protects the patient from futile measures and additional suffering. I admired that you and your attending reached out to the patient's oncologist, to ensure that nothing had been overlooked. You went the extra mile for this patient. Second, patients are living beings until they die, and their humanity must be respected and treated with compassion and dignity right up until the end of their lives. Third, while cure is not always possible, care and comfort always are. It is an abandonment of the patient to ever say, "There is nothing more I can do." Please hold on to these important and humane thoughts as you proceed through your training. They are the anchor needed to avoid cynicism and disillusion with the profession.

Comment #1

This sounds like the attending handled a difficult situation with grace and thoroughness, even across language differences.

Comment #2

I agree with you - I've witnessed these transitions as well, and they are striking. The attending is fully present in both cases, which is one factor I believe in how they manage moving from "death to laughter" with authenticity.

Comment #3

Your essay highlights a particular skill that many good attendings exhibit - the ability to be fully present no matter the external circumstances. Some situations are easier than others to manifest this ability - when people are laughing and enjoying themselves, there is a natural tendency to join in. There can be an opposite tendency to "withdraw" from pain, suffering, and death, and this is what the excellent physician must learn to overcome. It is by mastering one's fear and drawing closer to suffering that one conveys the sense of "being there" for the family. The family feels reassured and comforted; and the doctor has a sense of completion and witnessing.

Comment #1

What do you think went wrong here? How might the new resident have handled this situation differently without necessarily changing their medical recommendation?

Comment #2

Nicely framed! Medicine is a science, but it is also an art, and this means that reasonable physicians may differ in terms of their recommendations and treatment plans. As you note, it is important not to throw colleagues under the bus. At the same time, your primary responsibility is to provide what you think is optimal care to the patient. In this case, the first resident may have been unduly swayed by the patient's desire to deliver her baby as soon as possible. Or the resident may have felt it was safe and the patient's intense discomfort justified an induction. This speaks to your dilemma of honoring patient autonomy while protecting patient health. Here it is important to be able to distinguish between where your emotions are leading you and what you honestly believe to be the best interests of the patient.

Comment #3

You've done an excellent job of identifying the key dilemmas in this situation. First is the importance of managing disagreement in a professional and empathetic manner. This is always important so as not to undermine the patient's faith in the medical system as a whole. As you astutely point out, it may also have been the case that the patient misunderstood, and that the resident did not actually agree to perform an induction. The second point has to do with how disagreement among medical professionals, even when handled professionally, can be confusing and distressing for the patient. In this case, the patient thought her problem was solved - she could deliver her baby at 38 weeks and escape the misery she'd been enduring. Hurray! Now she learns that a new set of doctors don't agree. Hopes dashed! No wonder she will be disappointed, upset, and confused. In this situation, the important thing is to let her know that her doctors REALLY understand her distress and take it seriously. They need to demonstrate that, while they don't believe induction is the best path forward for her and her baby, they will do everything in their power to address her discomfort and empathize

with how difficult these last few weeks can be. Most moms-to-be do not want to do anything that might not be in the best interests of their baby; if they feel supported and cared about, they are more likely to go along with the new recommendations.

Comment #1

I am so sorry to hear this. As I'm sure you're well aware, to our great shame, this is not an unusual story in this country.

Comment #2

That is a very meaningful story. It shows that, far from "not caring" about their health, patients who have felt misunderstood or denigrated in the healthcare system can become engaged partners in their own health with a provider who shows concern and respect.

Comment #3

The story of your grandmother is heartbreaking, and as you've seen in hospitals and clinics, it is not unique. Your efforts with "Lily" are evidence that, when patients are treated with respect and dignity, most will respond very positively and become active participants in their own health. It is easy to blame the patient for "poor follow-through" or "nonadherence to treatment plan" when too often it is the physician's failure to communicate in a way that reaches the patient that creates these difficulties.

Comment #1

This is such a distressing but not unfamiliar situation. It offers a valuable opportunity to learn how to deal with the extremely fraught emotions in play.

Comment #2

I wonder what lay behind this request. Is he afraid of being without her, even in her current state? Is he hoping for a miracle? Does he feel it's better to have her, on any terms, than not have her? What does he think she would want? What does he think about her level of suffering? When you hear the family member's answers to such questions you can begin to determine where the conversation needs to go.

Comment #3

I'm sure this is all medically sound, but is this really the issue? It is the fallacy of saying - we can't save your wife - and thinking this will change the husband's feelings. He already likely knows this. Again, what is he asking for? Is the family waiting for some specially significant event? (A wedding,

an anniversary?). Is this a way of saying, I love my wife desperately and see palliation as "giving up"? Before launching into all the reasons why there is no further treatment that would be beneficial, it's important to understand what the family member is really saying.

Comment #4

Palliative usually models a much more compassionate, big picture approach, and I see this happened here as well. Thank goodness.

Comment #5

A wonderful message from this family member, saying, in effect, the patient accomplished her goal. She wanted to live long enough to see her son grow up, and that has happened. Covertly, it says to the rest of the family, it is okay to let go now.

Comment #6

This is an example of the family thinking shifting from their own pain (can't bear to lose her) to awareness of the patient's (pointless) suffering.

Comment #7

Again, same as above. The husband shifts his position from "do all possible" to "let's alleviate her suffering and let God decide."

Comment #8

This is an excellent recognition, Erica. It is respectful and humble. You cannot experience her grief, it is indeed her loss, not yours. But loss and grief are part of the human condition, and in this commonality we are all united.

Comment #9

this is EXACTLY it. Courage and vulnerability - being able to look into the heart of another's suffering and contain it requires strength; it also requires the vulnerability to accept that we are fragile human creatures who all experience suffering.

Comment #10

Absolutely right - I agree completely. Nevertheless, when we do not know how to behave in these situations, our sadness and discomfort can APPEAR as callousness and indifference. So we must be willing to take responsibility for the outcome, even though that was not our intent.

Comment #11

This was a deeply insightful essay. I'm very impressed. You recognized immediately the different negative and positive effects the various approaches of the attendings had on the family. I loved your sentence: "Being fully present with someone in pain requires courage and vulnerability." This sums up perfectly the qualities that are needed when biomedicine can no longer help the patient. This kind of presence can be deeply comforting and reassuring to families in these extremely high-stress moments of decision-making. It's wonderful that you've figured this out at such an early point in your career. You will have the rest of your professional life to develop and refine these skills, and the more you do so, the less fear you will feel in these situations, and the more gratitude for the privilege of being with families at this time.Finally, I really appreciated your point that the neurosurgery resident and the neurologist were not the "villains," but rather also suffering beings who were afraid and awkward in the face of their own discomfort. When our own feelings overpower the situation, the focus has shifted from the patient to the doctor, even though they may continue to talk about chemo regimens and surgery. Being aware of this pitfall is a critical first step in learning how to avoid it.

Comment #1

Well, this is a little disconcerting. However, using half-full philosophy, your patient has just given you lots of clues about how she wants to be treated - be humble, don't tell her what to do, don't order her around!

Comment #2

Skillfully done. She may or may not have been treated badly by this doctor, but she FELT unheard and this deserves to be acknowledged, no matter how the doctor behaved.

Comment #3

So the "loss" here was that you and the attending feel behind in the schedule. Hopefully you were able to make up the time without significantly shortchanging these patients. What was the "gain" in taking additional time with this patient; and how might that play out positively in future visits?

Comment #4

Excellent observation, and that is why we now talk about difficult encounters, not difficult patients, a term which also pleaces the entirety of the blame on the patient, without acknowledging contributions that may come from the physician.

Comment #5

Absolutely. When you find yourself in the midst of a difficult encounter, that should be a cue to learn more, never a justification for dismissing or demeaning a patient.

Comment #6

Thanks for an excellent essay. You demonstrated real empathy and respect for this patient, when it would have been easy to do otherwise. You were fully present with her, when part of you might have wanted to "flee," just avoid the whole situation (as too many doctors do). You listened in a way that helped her feel seen and heard. You earned her trust, a pretty remarkable feat considering where you started out.I completely agree that we should avoid speaking of "difficult patients." A better term is "difficult encounters," because it acknowledges that difficult situations arise in medicine, full of tension, frustration, even animosity, but suggests that these situations are rarely simply the fault of a "bad" patient, but rather have to do with complex dynamics BETWEEN doctor and patient. Perceiving difficulty should never be an excuse to blame or abandon a patient; rather it should trigger curiosity about the source of the difficulty as well as renewed effort to try to resolve it. Knowing how to remain centered and composed really helps in continuing to investigate the problem without judgment.

Comment #1

Your essay points out the difficulties in "educating" a patient across language and culture about a sensitive subject like diet. As you realize, what we eat is not only for nutritional value, but has strong cultural and familial symbolism. People share food at family and cultural gatherings, bonding as they do so. Changing what one eats is a big undertaking, and doing so without a culture and language in common adds to the challenges.Although it certainly might have been useful to have the son step out so that you could probe the mother's feelings about diet in private, I suspect that any successful intervention is going to involve the son's eating as well as the mom's since likely she cooks for him. Family and even community oriented shifts in eating habits have a higher likelihood of success than trying to change a single person's habits.Finally, I think I detected in your essay a desire to know more about the nutritional value of culturally familiar foods that you could recommend to patients. I respect this desire and agree that physicians in general could benefit from more knowledge in this area. In fact, the nutritional consultants who provide services at some clinics (e..g., FHC-SA) are usually very well-trained in culturally appropriate diet recommendations and are a great resource.

Comment #1

This is actually a great gift because it helps you anticipate he may not readily return to follow-up appointments with you either. You might consider asking him what he doesn't like about doctors, and what you can do to make visits more tolerable for him.

Comment #2

Good, this response shows you were listening and reinforcing him for his "courage" in coming to the doctor despite his discomfort.

Comment #3

And you can always try to empathize. "These are hard things to talk about, It might help both of us if I could get a sense of what you know about this disease. Would you be willing to talk with me a little?" And he may still refuse.

Comment #4

I see you trying very hard to find a way to connect with this patient - empathizing, using MI, looking for what WOULD meet his needs.

Comment #5

This encounter is a good example of trying many different avenues to connect with the patient - unfortunately, with limited success. If as you suspected the patient was using drugs, that becomes his #1 problem as it will be difficult to care for him adequately if he is actively using. A very high priority is trying to find a way to engage the patient in his own healthcare. One way to approach this is to surface the reality of missed appointments and his dislike of doctors and see if there were any steps that could be taken to ensure his compliance. As you suspected, if the patient is battling addiction, consistent medical care may be the last thing on his mind. One question that might shed light is to ask how he managed to keep his appointment today. Using an MI framework, you could spend a little time talking about this as a success experience, ask about other success experiences, and seek motivational triggers more broadly.The reality is that, in a single visit, you may not be able to override patterns that are longstanding. Thus the best chance this patient has is to establish continuity care. Despite your best efforts, the patient may still decline. So you do your best to address whatever medical issues you can in the moment and, most importantly, show the patient you actually care about him and are committed to helping him. Feeling that someone cares whether you live or die can actually make a big difference. I think your efforts with this patient on multiple fronts well-conveyed this message!

Comment #1

Actually pretty impressive that you were able to elicit this history. You must have established a good relationship with this patient despite language differences.

Comment #2

Thanks for sharing such a heartwarming story. As you no doubt already realize, these are the moments that doctors live for - the small things that make their jobs worthwhile. I really liked your awareness that despite language barriers (and now masks) we still have nonverbal communication skills at our disposal. I've sometimes thought that an unexpected benefit of interpreted interviews is that there might be less speaking and more listening! I'm glad your patient responded so positively to your interaction, and impressed that you were able to push past the stigma and shame so often associated with mental illness.

Comment #1

Many patients express ambivalence about medicine. They are hurting, so they seek help, but they are skeptical of the help they receive. Physicians sometimes say in exasperation, then why did they come to the doctor? But in fact, they both want and don't want to be there. The key is to win their trust so they are more accepting of physician recommendations.

Comment #2

You are doing a great job of looking beneath the rather judgmental phrase, "poor historian." The important question is what is making her a poor historian? Given her age, is it possibly she has some sort of cognitive impairment? As you suggest, is it a generational or cultural shortcoming? Answering this question will help you figure out how to proceed with this patient.

Comment #3

You raise two interesting questions. 1) How do you deal with a patient who may be reluctant to follow the prescribed treatment plan? 2) What does it mean to be a "poor historian?" In the first case, it is important not to judge patients who express ambivalence about their care. Many patients both want and don't want to seek medical help. When this is the case, your job is to understand their concerns and earn their trust so you find common ground. Regarding the issue of "poor historian," I like the way you interrogate this concept and think about the multiple reasons why this label might be applied to a patient. In most, although not all, cases, the patient is not intentionally being uncooperative. As you surmise, instead, the patient may be unable to provide an adequate history (by physician standards); or may have a different understanding of what an adequate history is; or may have different expectations of the physician's role and patient's role. For example, in other

cultures, a traditional healer will ask very few questions, and will make a diagnosis by taking the patient's pulse and observing other physical manifestations. So bottom-line it is important to figure out the source of the communicative difficulty, which in turn will point you in the best direction to move forward.

Comment #1

Ah, so the Chinese Medicine doctor made certain assumptions about Dr. Tran's TCM knowledge base because of her perceived ethnicity/last name etc. Ouch! Still, the scenario often arises that patients inquire about various CAM modalities and the physician doesn't have a great deal of knowledge in this area. So while the assumption of expertise based on ethnicity is stereotyping, the situation itself is not uncommon. I believe the physician has some professional obligation to research the patient's concerns or at least to be prepared to make a more appropriate referral.

Comment #2

Exactly. Perhaps the patient's persistence in assuming Dr. Tran had specialized knowledge was "racist," but the main point of the encounter was that the patient wanted advice about a potential herbal concoction she was about to assume; and I think the physician could have addressed that.

Comment #3

That's an excellent point, Gladys. By shutting down the patient's query in this instance, it makes it less likely she will be comfortable asking other questions in the future.

Comment #4

No of course not. It is unclear to me whether the emotion was shame b/c of an inadequate knowledge base; or annoyance at assumptions of expertise based on ethnicity. Either way, while correcting the patient's misunderstanding (or racism), it is still important to keep the main focus on the patient's needs.

Comment #5

This is a very interesting essay and I enjoyed the issues it raised. On the one hand, it is demeaning an stereotyping to make assumptions based on an individual's appearance/name/accent, or other superficial characteristics. So I feel Dr. Tran was perfectly right to correct the patient on this score. However, the patient had a legitimate medical need, which was to determine whether the tea she was going to consume was harmful or contraindicated for any reason. This is a question that might be put to any physician and deserves an answer. I think in this instance both issues could have been usefully addressed. The patient might learn that not every doctor who "looks Asian" (whatever that means!) is an expert in TCM. With a little research, the patient could have been reassured that the

tea was benign, been warned that the tea was harmful, or at worst referred to another physician with more expertise in this area. Understandably, the frustration that the attending felt at being racially typed might have interfered with her helping to answer her patient's question. This is a good lesson that being aware of our own emotions is important in delivering good clinical care.

Comment #1

Good awareness of your own and other US physicians' reflexive attitude of skepticism toward treatments they are not familiar with

Comment #2

Perfect, Helen. Curiosity can carry us past a lot of judgment and assumptions. Curiosity can also lead to greater empathy and understanding.

Comment #3

aking a little time to show curiosity about something new and unfamiliar; expressing interest in your patient and a sincere desire to help - these things activate trust and stimulate the patient's desire to engage in her own wellbeing. I'm glad you got a chance to see Dr. Kilgore in action. There are so many lessons to be learned from his modeling. As he says, Integrative Medicine should just be called Medicine, because there is a place for all these skills in every specialty.

Comment #1

No wonder. Experienced clinicians are really struggling with telemedicine as well; and when it's phone only, it is really tough.

Comment #2

It's really important to be aware of emotions such as frustration, irritation, and even anger, because there's a lot in clinical practice (beyond patients' diseases) that is frustrating. Where learning can occur is, once we recognize our frustration, how can we ensure it does not complicate the encounter and how might it be used constructively?

Comment #3

This is a phrase that often comes to mind when an encounter is not going well and the patient does not seem to adhere to recommendations. It is worth asking ourselves, what does this phrase mean? Why do we say it (or think it), and what are the potential consequences of so doing?

Comment #4

Excellent, so through further probing, you begin to discover WHY the patient "doesn't care" about her health.

Comment #5

Huy, I really appreciate your capacity to take a step back, learn from the resident's teaching, and enlarge your understanding of the patient.

Comment #6

Really value your essay and the arc of growth it describes in you. Yes, there is much to be frustrated with in the practice of real medicine, and it is easy to blame individual interpreters, patients, or even ourselves. While taking personal responsibility for one's health or for doing one's job effectively is important, it is equally if not more important to be cognizant of the structural, systemic factors at work that complicate and often impede providing optimal health care. Immigration status and fear of deportation is one example; underpaid, overworked, sometimes disrespected interpreters is another. All systems are imperfect, and the healthcare system perhaps especially so. It is important to learn how to work within it in as compassionate and humane a manner as possible, while also doing what we can to change it. I also wanted to comment on your awareness of your own frustrated feelings, which was commendable. Unrecognized, such feelings can often interfere with the doctor-patient relationship. Although not in so many words, it is easy to unintentionally convey blame, judgment, impatience, annoyance nonverbally, through physical actions or tone of voice. Questioning our initial explanations for our frustration ("this patient doesn't care about herself") and complicating these explanations can often result in more empathy and patience. I respect that in the space of one brief encounter you were able to show such growth and awareness.

Comment #1

It sounds like you/the resident and the patient were at an impasse. I'm curious - why was she opposed to medication? Was it simply the idea that she was "not sick"? What did she think about her hallucinations and pseudocyesis? Did she believe God/Devil were talking to her and that, she was indeed pregnant?

Comment #2

When patients do not change their views according to our timetables, it's easy to conclude they will never change. This is not always the case. With patience and persistence, people often come around..

Comment #3

This was an interesting situation to read about, although I'm sure a very frustrating one to live. You knew what could help this patient, yet she adamantly resisted because she believed she was "not sick" (of course we see this frequently with schizophrenia and other psychoses). I would love to hear more (in class) about what might have happened on day 8 for her to begin to change her mind. Did the conflict with her roommate catch her attention? Was it your persistence in discussing the benefits of medication with her? I respect that, despite your understandable frustration, you stayed the course and did not give up on her. Often, that kind of patient persistence convinces the patient that you have their wellbeing at heart and persuades them to follow your recommendations.

Comment #1

Yes, everyone in medicine is still figuring out how to make telehealth/phone encounters successful!

Comment #2

Yes, you are right it is all about listening, but it is also true that communication is a two-way street. I wonder why your patient wanted to distract you? Why do you think he did not want to engage with the matter at hand? Might he have been afraid? In "denial"?

Comment #3

Feelings of frustration are natural and normal, so please don't feel bad. What's important is what you can learn from them? How can they help you better address what was happening between you and your patient?

Comment #4

It sounds to me as though you were doing a very thoughtful and conscientious job of trying to balance many factors in this encounter.

Comment #5

Thank you for this thoughtful and transparent essay. Your conversation with your preceptor showed that some encounters are more challenging than others; but a skillful preceptor will find ways of simultaneously connecting with the patient and setting limits. Once the patient trusts you and feels you have their best interests at heart, it is easier to redirect them and set priorities for a specific encounter. As you pointed out, listening is crucial, and letting the patient know you've actually heard them by paraphrasing (it sounds like you're concerned about x,y, and z) is equally crucial. Feelings such as frustration, irritation, or even anger can be useful in an encounter because they let you know things are not going well. No problem. The mistake comes when we try to justify the feelings by

blaming the patient. A better strategy is to think about what you can do to change the dynamics - paraphrase more, set a limit, even "surface" the problem by making it explicit ("I'm getting the feeling we aren't communicating very well. Do you feel I'm hearing you? Do you feel you're hearing me?").Finally, when you see a repeating pattern of behavior in a patient (not just a bad day), it's worth considering where this is coming from. Are there language problems? Cognitive or mental health issues? Is the patient anxious about their health condition? Are they so afraid they are in denial? Do they feel blamed for their out-of-control diabetes and want to avoid recrimination? When you begin to understand what motivates the patient, you can begin to understand how to change the interaction in a more positive direction.

Comment #1

These are very natural feelings where you feel you're being manipulated and used. I really respect that you were willing to sit with these feelings a bit and think about the issues they raised more deeply.

Comment #2

Excellent. Of course you know that pain is a very subjective experience. what is unclear from your account is whether the pain this patient is experiencing is the kind that disability will help. Regardless, it helps to remember that the patient is trying to reduce his suffering in the best way he knows, and that his behavior has less to do with you and more to do with his own sense of being trapped and helpless.

Comment #3

Very honest and accurate insight! Privilege allows many of us options that are not available to other less-privileged people. The solutions that occur to us may or may not be relevant to their lives. The best thing I've learned is to make room for the patient to tackle their own problems - with support and limits but also with trust that they too have solutions, sometimes better than ours.

Comment #4

And it's worth considering that there may be many ways of "calling out" someone who is lying - with anger is one way; having an honest but compassionate discussion is another.

Comment #5

I have great respect for the way you complicated this encounter with a "disability-seeking" patient. You acknowledged that the patient might be dissembling or at least exaggerating his symptoms in order to obtain a piece of paper which could stabilize his financial situation. You also recognized your own reflexive assumptions and the biases that privilege can easily generate. There are no

simple answers to solving this situation - indeed perhaps no answers at all - but at the least you can honestly witness the patient's situation without engaging in simplistic blame and judgment. From a place of thoughtful reflection, you can compassionately explore whether disability is the proper remedy for the patient's suffering and determine whether there might be more beneficial paths forward for him (in our current society, there may not be). But by avoiding simplistic patient blame, you can demonstrate your respect for him as a person, while acknowledging the limited options he may have available. On the other hand, by developing trust and respect, you may discover resources internal and external that can be mobilized to support your patient.

Comment #1

These technical difficulties in themselves get the interview off to a problematic start!

Comment #2

It sounds to me like you were using nonverbal skills appropriate to a cross-language encounter.

Comment #3

Yes, I agree that it can be very difficult to redirect the patient's focus and communication away from the iPad and back to the provider. Sometimes, having the interpreter directly explain how it is helpful for the patient to look at and speak to the doctor, even if she cannot understand everything being said, can encourage the patient to remain connected with you. But it's hard!

Comment #4

All your points about the difficulty of an interpreted interview are well-taken, and this is an especially important one. It is very easy for the primary connection to be between interpreter and patient, not physician and patient. In part you want to take advantage of this by ensuring that the interpreter provides thorough explanations and addresses all the patient's concerns. However, you want to do what you can to develop relationship as well. Your attempt to use nonverbal forms of communication to do so was a very good idea, although in this case it wasn't especially effective.

Comment #5

Sadly I think your experience is not uncommon. It IS challenging to connect emotionally with a patient across language and culture. Your strategy of leaning on nonverbal communication was a really good one, and sometimes this does result in connection. Requesting that your patient speak directly can also be effective, although sometimes it is just awkward! Finally, on a rotation you are at a disadvantage that you will likely not see this particular patient again. If you had a continuity relationship with the patient, you would have a better opportunity to build relationship over time, as I have witnessed many family medicine residents do. I think the first step is to recognize the

challenge, and then it is to continue to look for creative ways of connecting with patients whose background and language differ from your own. It's not easy, for sure, but it can be rewarding.

Comment #1

There was a terrible misunderstanding in this case, and the patient understandably feels misled, exploited and abandoned. Winning back trust will be difficult if not impossible, but I wonder how you might try.

Comment #2

Does this kind of defensiveness seem like the best way to deal with the patient's feelings?

Comment #3

Absolutely correct - this is not a "reasonable" error. There should always be multiple and detailed checks "along the way" to ensure that a patient has solid understanding of proposed medications, interventions, procedures, and is actually providing INFORMED consent. Too often, especially when language and cultural differences are involved, people take short-cuts through these processes. Usually the one who suffers the most as a result is the patient.

Comment #4

To a patient who has been discriminated against most of her life, a flippant "I'm not anti-trans" (or racist, or misogynist) is, as you say dismissive. It is quite possible that the patient picked up on something in the resident's or others' demeanor that did make her feel uncomfortable or judged.

Comment #5

This is a tricky issue. When one person accuses another of bias, it's natural (but not usually productive) to say, "No, you're wrong. I'm not anti-trans etc." The issue is not only whether the statement is true or not; it is also how to deal with the patient's PERCEPTION. If there is time to go down that road (and it is a worthwhile issue, since the patient will likely not trust a physician whom she perceives as anti-trans), then it is usually more useful to apologize and ask for clarification: "I'm sorry. I can see something I said/did has hurt you/made you uncomfortable. My intention is to take the best possible care of you. Can you help me see what I did to make you uncomfortable so that I can avoid this in the future?"

Comment #6

This was a really well-observed encounter on your part. You did a great job of analyzing the likely source of a really terrible misunderstanding and of empathizing with the patient's distress and anger. You also showed excellent insight into the shortcomings of the resident/attending's responses (of

course we both know that hindsight is 20/20, but that's why we reflect, so that when a similar situation arises in real time, we can handle it a bit differently). It's natural to feel defensive when someone accuse us of wrongdoing. But simply denying it makes the other feel unheard. It's better to apologize for hurt caused (whether intentional or unintentional), and clarify what created that perception in the patient. Language barriers are a reality of clinical practice, and this extends to doctors and patients who both speak English and therefore assume they share a language. Patients misunderstand doctors more often than not; so special attention should always be paid to ensure communication is clear and accurate. When actual language and cultural differences are in play, this is even more crucial. It takes a little more time and care at the front end, but can avoid really distressing (and unnecessary) outcomes such as the one you describe.

Comment #1

This is a strong decision. I wonder if you feel that it reflects the physician's frustration, the best interests of the patient, or some of both?

Comment #2

I agree that the patient broke trust with his physician. I wonder whether the deal itself was a bit of a set-up. Were there mini-goals set along the way? Was there discussion of consequences if the larger goal was not meant? Did Dr. W share his need for the patient to meet him halfway? I worry that there may have been some missing steps between the "deal" and the termination.

Comment #3

What are your thoughts about whether another doctor would be more successful with this patient? Is this stand-off simply a result of a mismatch between doctor and patient?

Comment #4

Do you think the problem was that the patient wasn't comfortable with Dr. W?

Comment #5

this is a fascinating ethical issue. It is true that physicians have a right to terminate a patient, although usually I have seen this occur when the patient is physically or verbally aggressive to physician or staff. There are so many questions to think about here:

1) Why did the patient keep coming back to this doctor? What was he looking for from his healthcare?

2) Do you see the patient's refusal to try medication as a form of nonadherence? If so, might there be other approaches to intervene with the patient, such as motivational interviewing, that could be more effective?

3) How might you construct a "deal" with a patient in similar circumstances? What elements might increase its likelihood of success?

4) When you've invested a lot of time and energy in a patient, how do you manage your own frustration at lack of efficacy?

5) When is it in the patient's best interest for the physician to terminate care; and when is it a way of "punishing" the patient?

These questions have no easy answers, but they are worth pondering. I hope we are able to discuss further in class

---

Comment #1

Why do you think that was? When the patient is not convinced by medical logic, it can suggest that there are other issues - maybe she thinks she has cancer, or she is depressed, or she doesn't trust doctors to treat her fairly. It always helps to try to figure out the source of resistance so you can address it.

Comment #2

Wow, what a skillful physician. Why do you suppose this approach disarmed the patient?

Comment #3

Fascinating, right? You had a wonderful opportunity to see a transformation from resistance and difficulty to receptivity and trust.

Comment #4

I commend your attending for great patient care and awesome teaching. I commend you as well for understanding what was the most important lesson you learned from that encounter. Information and explanation are useful tools, but they are not compelling in every situation. It is so important, as your attending pointed out, to really understand a patient's psychology - their hopes, fears, expectations. In this case, the patient was reassured when the attending showed by his interest in her life that he saw her as a person. This allowed her to accept and trust his expertise. I know you will remember this experience!

Comment #1

This is an important point, Jason. A physician may have good language skills and still miss nuances or not understand regional differences. When it becomes clear that miscommunications are occurring, it is important to use an interpreter, even though it may slow down the encounter.

Comment #2

In a situation like this, I wonder WHY it was the "best course" for her. Was it because it was "quick" and she couldn't afford to wait for the better treatment? Was she afraid that she couldn't afford a specialist? It is distressing when the "best course" is simply the only realistic course.

Comment #3

I'm not sure it's that she has a different view, rather that she cannot see other options for herself.

Comment #4

And to this I would add that we institute a more equitable healthcare system that does not require patients to make these kinds of choices.

Comment #5

this was a thoughtful essay that highlighted the consequences of a healthcare system that offers only limited options for patients at the lower end of the economic ladder. This patient's problem was not life-threatening or even unduly "serious," but for her it compromised her livelihood. Yet she chose to forego the optimal treatment (or at least consultation with an appropriate specialist), perhaps partly out of fear of the unknown, but also likely out of financial considerations. If healthcare is a right rather than a privilege, then this is fundamentally wrong.

I also appreciated your recognition that coming from a background of greater privilege, you were able to prioritize health and medical care as of the utmost importance, an option which might not have been available to this patient. However, although this is not your experience, your were able to relate to it through your immigrant parents, who also placed work above health when they could. In this way you showed great empathy for the unfair choices this patient was forced to make.

Comment #1

So this sounds like an extremely frustrating and annoying patient. Your sympathies, understandably, lie with his long-suffering mom and the medical team that has to care for him. What is going on here? Are there psych/personality disorder issues? Has his mom's parenting led him to think the world owes him? Is this where the lack of gratitude comes from?

Comment #2

I think challenging the patient's reality can be very effective. You sound like you were (understandably again) fed up with this patient's entitled, rude and unappreciative behavior. So questioning his assumptions is good. Can this be done in a way that expresses caring and compassion rather than irritation?

Comment #3

Interesting comment. It may not have been your place to defend the attending - although I've certainly seen instances where a medical student or resident has advocated for the attending with a racist patient, and it seemed a wonderful expression of team solidarity to me - but it sounds like you were speaking not only about the attending but about the team, which seems very appropriate to me.

Comment #4

This is a good example of meeting the patient where he is, finding common ground, building a relationship and from that starting point being able to achieve better communication and cooperation.

Comment #5

I wonder what conclusions you drew from this experience. There is no question that this was a hard patient to deal with. He was uncooperative, disrespectful and ungrateful. Certainly a very frustrating triad! Why do you think the second attending talking with him about Star Wars Legos was so effective? Do you think she experienced similar frustration as the previous attending? If so, how was she able to transmute it, or at least add curiosity into the mix? Patients like this gentleman pose special challenges, but if you can win them over, at least to some extent, everyone's job becomes easier, and the patient gets better care, which is really the ultimate goal. As a by-product, the physician (or medical student) will feel less frustrated and more satisfied.

Comment #1

Good awareness Jeff that you felt more uncomfortable than your patient and her son - so that your primary task was overcoming your own discomfort to pursue an appropriate line of questioning.

Comment #2

Kind of cute. Once again, she seemed more comfortable than you. Nevertheless, I think your caution was completely appropriate. In venturing into waters of religious/cultural difference, proceed slowly and take your cues from your patient.

Comment #3

Good point. Asking your patient (of any background) what they are comfortable with in terms of questions and PE is always the best way to avoid mistaken assumptions.

Comment #4

you make some really interesting observations about the intersection of religion and health. Whatever your patient's eventual diagnosis, knowing how diligently she practices her faith will be important in crafting an appropriate treatment plan.

You also make an excellent point about assumptions based on our superficial knowledge of a patient. Although it is impossible to be completely assumption-free, when possible always ask (as you note), and hold your assumptions lightly, ready to alter them on the basis of additional information.

Finally, I appreciated your awareness that sometimes the doctor, or the medical student, might feel more uncomfortable than the patient. Then the task becomes not putting the patient at ease, but putting oneself at ease, so the encounter can proceed as smoothly as possible.

Comment #1

Good for the doctor (medical student) and good for the patient, as research shows patients often have better outcomes with doctors who share background, culture, gender, race/ethnicity, language with them.

Comment #2

This decision was a good one, I think. Letting the patient lead can build trust and give them a sense of control so that it becomes easier to redirect later back to the sensitive topic.

Comment #3

That is very touching. I'm thinking how often that question can be a wedge to express insider-outsider convictions, resentment, or even hatred. In this case, it became the door to a sense of solidarity and trust. I believe that it was not only being a "familiar face," but also your thoughtful, respectful, patient-centered approach that earned your patient's trust and appreciation.

Comment #4

this was a lovely essay. Indirectly, it addresses the relative lack of diversity in the physician workforce, and how important it is for BIPOC populations to have the opportunity to receive care from physicians of similar backgrounds and experiences. I think in addition to this factor, it was the care, respect and sensitivity with which you treated this patient that resulted in trust and rapport. From the very beginning, when you set a positive mental attitude (excited) and invested time in

finding an appropriate interpreter; to being sensitive to age and gender differences and letting the patient guide the conversation initially; to empathizing with his fears regarding surgery you showed yourself to be an attentiv

---

Comment #1

This is a good example of how what might be a minor problem for one can be livelihood and identity threatening for another.

Comment #2

There is no reason you should have known this. However, we often make assumptions about quality of care for underserved patients that are not always accurate.

Comment #3

Yes, me too. Think about why this is, and what an attending may have to overcome in terms of internal and external obstacles to commit to a fuller communication through an interpreter.

Comment #4

Thank you for such an honest reflection about how your assumptions about care at an FQHC might have influenced your interactions with the patient, causing you to rely on limited shared language rather than actively seeking an interpreter. Your level of insights suggests to me that this mistake, which as you note is made daily by many attendings and residents, won't recur with you.

I think all of us have to be on guard to ensure that underserved patients receive the best quality care we are able to provide. There are already so many structural injustices and inequalities built into the system that extra vigilance and effort are often required. Even so, we as individuals cannot right all the unfairness that exists until we are able to achieve systemic change. I applaud your self-awareness and sensitivity.

Comment #1

This is a really interesting thought, Joanna. Sometimes, out of cultural sensitivity, we may be hesitant to give patients information that might benefit them. Of course, such education has to be approached carefully, but per above, I can see you excel at reading nonverbal cues.

Comment #2

thanks for providing this informative link. There is a fine line between respecting cultural practices and beliefs and inadvertently contributing to the oppression of women from certain backgrounds by not challenging misinformation or inaccurate beliefs. It's tricky, but unless the patient herself rejects receiving information, I believe useful patient education can occur across cultures, if conducted in a way that acknowledges cultural differences, beliefs, and expectations.

On another note, I was impressed by your careful observation of this patient, her hesitancy about "letting you in". I was also impressed that you earned her trust so that she did disclose some of her personal struggles, and was able to express her views on pap smears and the flu vaccine with you. In addition to your emotional intelligence, the fact that you are a woman similar in age to the patient may have stimulated some positive transference.

Comment #1

Good planning ahead. Knowing your patient, as you clearly did, can help adjust your workload so you are not caught unawares by a more complex patient.

Comment #2

i really appreciated your efforts to connect with this patient, and how you noticed his small nonverbal cues and by paying careful attention to all the interpreter told you. You and your classmates are working and learning under extremely tough conditions, and it requires flexibility and creativity and trying to make the best of often tough situations. It sounds like you're adapting well. Congratulations!

Comment #1

Great job. You were beginning the process of placing the patient in the context of his life. Showing that you are interested in the patient as a person is a good way of establishing trust, which seems like exactly what started to happen.

Comment #2

Okay, this can be a sensitive topic for patients from a variety of backgrounds; and it's impressive that you were able to get the patient to open up about his concern in a single visit.

Comment #3

I think your nonjudgmental, neutral tone in using more explicit language was effective in normalizing the patient's concerns.

Comment #4

from the moment you recognized something more might be going on with your patient than he was able initially to express; to the conclusion when you were able to name his problem - erectile dysfunction - nonjudgmentally and calmly, normalizing the conversation, thus making it possible for him to consider appropriate medication. While it is impossible to fully understand the nuances of another person's culture, particularly after superficial exposure, simply being aware that your patients may have different norms, expectations, and assumptions about health and illness can make you more sensitive, more cautious, and more creative in how to approach them to ensure a successful encounter.

Comment #1

You and the team must have done an excellent job of communicating with this patient for him to have made such a dramatic turn-around. Often, the patient is asking for help, but doesn't trust that he will get it or that he will benefit from it; so simultaneously he rejects it. But the reason he's come to the hospital is to ask for help. Usually, if you persist with kindness and concern, the patient will accept what he really wants in the first place.

Comment #2

I'm sure this was very uncomfortable for you - and very unwarranted. What must have the patient been feeling to cry over a piece of pie? How out of control he must have felt, how sad and helpless.

Comment #3

Perhaps this stemmed from his own fear, helplessness, and lack of trust. What he sees is that his condition is deteriorating. The doctors are not able to "fix" him. He starts asking himself - do they really care about me? Are they trying their hardest? Have the dismissed me because I'm homeless? How can this be happening to me? Maybe with other doctors it would not be happening. So these are some of the questions that would need to be surfaced, and then addressed.

Comment #4

I wonder if it is about lack of appreciation so much as his own despair and lack of control. Of course, it is wrong for him to take out his feelings on you, very inappropriate, but sometimes it helps if you can learn to not take such outbursts personally and look beyond the patient's misbehavior to see his pain and suffering.

Comment #5

I know you will encounter many patients who are grateful and appreciative of your efforts, and recognize that you have devoted your life to helping and healing them. It is also true that you will

have patients who seem "ungrateful", who fight you every step of the way. It is very hard to deal with these patients, but they are your patients too and also deserve your best. Usually, in my experience, the kind of misbehavior your describe stems from fear, despair, and helplessness. As you recognized at the outset, this man's life was spiraling out of control. He probably yearns for a better life, in which he doesn't have severe diabetes, he is in a loving relationship, and he has a roof over his head. Medicine cannot give him any of these things, yet it is the only way he knows how to ask for help. When he realizes his life will not substantially change, he feels angry, and underneath he feels afraid. He lashes out, distressed that you cannot "fix" him.

The shift from angry to cooperative back to angry and resistant is an interesting one. When you see something strange like this, be curious. Why has this happened? What is driving this shift in behavior? Knowing what motivates this sudden belligerence may help you to solve it.

In these circumstances, trying to be patient, to witness the patient's suffering, to reiterate your commitment over and over, and to involve social services may (and only may!) prevent the patient from leaving AMA. Once the patient realizes you are truly dedicated to his care, that what you can do is limited, but you will do all you can, often in the end they will accept your aid.

Comment #1

So it sounds as though the patient would be very mistrustful about anything physicians told him; plus he would not want anything to interfere with his job, so either diagnosis would not be welcome.

Comment #2

By listening to him and trying to address his needs, you began to earn his trust. You became someone who appeared to be on his side.

Comment #3

Exactly. Well put. Patients feel vulnerable, isolated, and out of control. They want to be seen and heard. They want someone caring for them who seems to care about them.

Comment #3

The label "difficult patient" is far too often a way of pushing away patients with whom we have difficulties, as it places all the responsibility for the problem on the patient, while leaving the doctor floating above it all.

Comment #4

Your essay makes some excellent points. Listening with interest and respect is one of the best ways we have of establishing connection with patients and building trust. Your interaction with the patient enabled him to feel heard and seen, as though he mattered. I couldn't agree more that, very often, when you are able to connect with a patient such that the patient feels you care about them, the "difficulty" that was experienced either disappears or diminishes.

Comment #1

this sounds like a very difficult encounter. Doctors are sometimes thrown off their game when they cannot provide answers - since that is what they are trained to do and what people expect them to do. It can be easy to blame the patient - why are you complaining? There's nothing wrong with you. This is generally not a productive approach. Regardless of the lack of findings, the patient is suffering. That should always be the physician's first concern - to acknowledge the reality of this suffering, to take it seriously. The patient feels alone and frightened, so it is particularly important that the physician not abandon her emotionally by pushing her away. Of course, it is okay to say you've come to the end of your diagnostic ability, but this should be said with kindness and humility.

I think you already understand this very well. If the specialist must send the patient back to the pcp, then they should do so in a caring, empathetic manner. Better yet would be for them to be willing to think about other possibilities for either diagnosis or management as you suggest. Dismissing and blaming the patient may make the physician feel better, but it is a nontherapeutic approach.

Comment #1

It's always a good idea to ask about CAM remedies as large numbers of people utilize them but may not always disclose them to an allopathic physician.

Comment #2

it certainly sounds as though the patient's self-healing practices were working effectively for him; and that he was satisfied with their impact on his pain. It's great that he was so open and shared all of his alternative approaches. The only thing I'm curious about was the reason for his visit to the clinic. Did the patient want validation for his CAM use? Did he want to make sure that western doctors would approve his interventions? Was the purpose of the visit merely to inform his doctors, so they'd know what he was doing? In an case, patients usually try their own treatments before seeking medical assistance; and it is always useful to know what they've tried or are still trying.

Comment #1

Exactly. Your agenda is that you want to talk about her medical issues; her agenda is that she is angry and thinking about transferring care. In this case her need is so intense that, until she feels seen and heard, it will be very difficult to take a history and go about business and usual.

Comment #2

It can be hard to remain nondefensive in such a situation. You did nothing wrong, you barely walked into the room,but the patient ventstheir anger at you and expects you to clean up the mess.

Comment #3

That's a great attitude. Patients should be able to advocate for themselves; and as their physician, you can create a context that encourages them and validates them for doing so.

Comment #4

The possibilit of recurrence in a cancer pt is always omnipresent in the minds of cancer patients, no matter how many years in remission. It's easy for patients to be very anxious around testing and imaging that might consign them to this alternative world. So I think your patient's strong reaction was a lot her anxiety talking. This is the perennial lesson of medicine - "don't take it personally" (except of course when you should!). So often when patients are cranky or angry or otherwise upset, it truly is not about you, but is an expression of their own frustration and fear.

This patient's words were so instructive: "no one cares about me." How could she trust her doctors and nurses if she felt no one cared, she was just a body to them? To me, this reinforces the importance of making sure every patient feels valued, seen, and heard. It is only from this foundation that the physician can truly care for her patient.

Comment #1

This seems very appropriate. It might have helped to give pt and daughter a heads up that you would be asking questions and that this was part of the process to ensure the pt's maximum comfort and correct administration of the drug.

Comment #2

Ah, this shows why it is called FAMILY medicine! I wonder why the daughter thought she had the medical knowledge to answer your questions. What did you deduce from her interruptions? Was she concerned that her mom was not getting adequate treatment? Do you feel she was appropriately involved in the permission process?

Comment #3

This is quite understandable. Now, in retrospect, what might be some options for responding to her intrusion? What would be your goals in responding to her? How might you best accomplish them?

Comment #4

Excellent insight - or even situations where she FELT the mom was receiving poor care because of her language disadvantage. Perhaps trying to pair with the daughter - I can see how well you're looking out for your mom and how you want the best for her. That's what I want too, and that's why I'm making extra sure I do everything exactly right for her.

Comment #5

You have a good insight that, despite you and your preceptor's efforts to communicate directly with her in Spanish, the patient may have felt at a disadvantage because of the lack of a shared language. If this were the case, the daughter may have felt special pressure to "be her voice." Her intrusions (certainly not appropriate) may have been intended less as criticisms of you and more as evidence (to her mom and to herself) that she was acting as her advocate. You are quite right that patients and families bring their medical histories with them, and these include not only the tests run, procedures performed, and drugs prescribed, but also how they were treated as human beings, whether they received respect and care. Keeping this in mind helps to avoid personalizing patients' and families' comments too much. In a sense, you need to "prove" that you are trustworthy, even though you personally have done nothing to deserve lack of trust. You can do this best by remaining compassionate and calm, as your attending modeled, and as in fact you yourself did, whatever your inner feelings.

In terms of an actual response, the daughter's comments might have triggered your own insecurities about attempting a new procedure. Our natural reaction is to respond defensively ("I know what I'm doing") or with power ("please be quiet"). But you have other choices, for example, thanking the patient for her concern; and bonding with her over the shared goal of taking the best possible care of the mom. Proceeding in this way can lessen the tension that everyone in the room is feeling and focus on common ground without making anyone "wrong."

Comment #1

It is easy to take things personally, but more often than not, although you may be the target of annoyance or anger, you are rarely the cause. While it is always good to reflect on your own behavior in case there is something to be learned, it is often the case that fear, pain, anxiety about the patient's medical circumstances or their life situation is driving the behavior.

Comment #2

Yes, I know this has been a confusing and distressing situation for many medical students - especially now that you have been pulled from hospital and clinics. I hope you will consider that, right now, everyone is essential. If you cannot help by learning from and taking care of patients because of the emergent crisis, I know there will be other ways to assist and support the front-line physicians. By staying engaged with the medical community, you will learn a lot about how physicians manage in times of crisis.

Comment #3

These worries seem very fair to me.I wish I could answer these questions in terms of content, but I cannot. As you know, it is a rapidly evolving situation. Although I may be mistaken, it seems to me that smart and committed people are trying to figure out answers in a completely novel (sorry) situation - and the answers will apply nationally, not just to you at UCI or California.

Comment #4

I understand not feeling supported, even hindered by the very system that is supposed to help and train you. I hope that since you wrote this essay, answers are starting to emerge. If not, perhaps we can chat in person, and I'd be happy to convey your concerns to the decision-makers, anonymously if you like.

Comment #5

Justine, I am so very sorry to hear this. Of course this is adding to your stress and worry. I do hope your father does well; and I cannot really imagine your anguish at not being able to be with him at

this time. The world has changed under our feet, and it seems frightening and unfair. Somehow we are trying to find a way forward; and what will help is the feeling of being supported and aided by others. You deserve that from your educational system.

Comment #6

I hear your frustration and confusion about how your educational needs and those of your classmates and indeed all medical students are going to be addressed. Even closer to the bone, I hear your concern for your father and the distress that you cannot be with him at this critical time. We are dealing with tremendous uncertainty and loss of control. We are trying to live in a bewildering and scary world, where we've lost so many degrees of freedom. I think the only way we will get through this is by pulling together; and if you don't feel that from our educational leaders that is very disappointing. Please talk with me privately if you continue to feel you are not getting adequate answers, and I will do what I can to help.

Comment #1

I think you nailed the meaning behind these reactions. How do you think the clinic manager felt as a result of this response? What do you think would be a better way to respond to the manager's frustration?

Comment #2

Ah, leading from the bottom :-). I'm so grateful you responded in this way. Someone on the team is asking for help. You either offer help or figure out a way together to get help. It is rarely a good idea to ignore the problem!

Comment #3

Oh boy, this did not go as planned. Welcome to clinical medicine :-) I think one of the skills of a good clinician is always being prepared for the unexpected - being light on your feet so you can adapt your plan (let's use the handy dandy ipad interpreter) to exigencies on the ground. It seemed as though you walked into the middle of a lot of family dynamics as well.

Comment #4

So one thing you learned was that there was a lot more going on than simply frustration at the long wait. The husband was worried the patient's TB had returned, and felt helpless that he did not understand how to follow-up.

Comment #5

I agree you may have needed the husband to leave. How you achieve this goal matters. Although it sounds very frustrating to deal with this individual, from his perspective he is probably advocating for his wife. Acknowledging this might appease him, and make it more likely that he could accept stepping out for a moment without loss of face.

Comment #6

While it is always valuable to review difficult encounters to see what we can learn from them, it is probably less useful to try to determine fault. The husband sounds frustrating; he also sounds scared and overwhelmed. The pcp probably thought they did a good job of explaining next steps. You tried to help and, as a lowly third year, took on a challenging patient. The focus should be on learning where things went off the rails and how the damage can be ameliorated.

Comment #7

What do you think the underlying problem was in this encounter? I suspect it was about lack of trust, perhaps a feeling that the pcp did not take the patient's concerns seriously; or that she wasn't getting good care. It is especially easy to feel this way if you come from a different country and are more comfortable conversing in a different language. Time is always short, but perhaps figuring out how to set the patient and husband at ease and letting them know they were really seen and heard could have helped.

Comment #8

Thank you for your honesty in writing this reflection. This was a very difficult and unsatisfying encounter. The image of the mask in the trash lingers in my mind accompanied by a feeling of frustration and disappointment. Clearly this was not the outcome you or the attending desired.

I think the key issue in learning something from this event is trying to understand the source of the husband's anger. Why was he so upset? It was certainly more than the hour wait, although this undoubtedly exacerbated his frustration. Often, at the root of anger is fear. So what might the patient be afraid of? Answering this question might provide useful thoughts about how to move forward to win his - and his wife's trust.

I keep coming back to the fact that when the clinic manager asked for help, you were the only one to step forward. You should pat yourself on the back for this generous and useful act. It was absolutely the right thing to do, and is a great example of responding to the need at hand. You did something similar in trying to interact through iPad with the husband; and in trying to establish a connection

directly with your patient. So while I think there are lessons to be learned, there's a lot here to feel proud about.

Comment #1

Patients often drop the real reason for their seeking care right before the physician is about to leave the room. This can be frustrating, as the time allotted for the visit is already used up. It can help fend this off by mentioning early in the interview that patients often want to discuss sensitive personal topics, that that is why you (the doctor, or student-doctor) are there, and your only goal is to help him with ALL his problems as much as you can. Basically, you try to normalize talking about sensitive topics.

Comment #2

This is an unfortunate example of physicians' agendas overpowering that of the patient. If what the patient considers important is not addressed, the patient will likely go looking for another provider.

Comment #3

Hmm. Not sure I understand what was going on. Was the patient angry about the inattentiveness of his previous care, and displacing this anger onto you and the attending?

Comment #4

This is a good point from a medical perspective - it links the patient's agenda and the physician's agenda. However, before offering this explanation, it's crucial that the patient's frustration be seen, heard, and acknowledged. Otherwise, the patient may feel that no one is listening to him.

Comment #5

When patients are kind, they're telling us something. When they're yelling and aggressive, they're also telling us something. If, instead of being defensive, we are curious about what they are communicating, you are absolutely right - we will learn a lot. In this case, the patient may have been saying, No one listened to me. I feel ashamed and angry and disrespected. Are you going to be any different?

Comment #6

Again, excellent imaginative speculation about the patient's anger. It is very appropriate to formulate such hypotheses (just as you would do in making a medical diagnosis) and then see to what extent they are supported by further evidence.

Comment #7

your essay showed impressive awareness and insight. I particularly respect your conclusion that, by paying attention and carefully considering patients' emotions, we can always learn something that will help in their care. It is not always immediately obvious what their emotion is trying to tell us; thus it is very appropriate, just as you did, to think imaginatively about what might be causing the emotion, and then, as the conversation continues, adjust your hypothesis based on what the patient continues to disclose.

Based on the picture your presented, your interpretations of this patient's aggressiveness make a lot of sense. First, the patient felt that his primary concern had been ignored and disrespected by previous physicians. Second, his other doctors had not taken the time to link their priorities (diabetes and HTN) to the patient's (ED) so he had no chance to understand that they actually shared common ground.

You've discovered an important principle that you will be able to use in every subsequent clinical encounter. Instead of getting hooked by patient's emotions, you can attend to them with curiosity and kindness) to better understand your patient and thus have more effective interactions and ultimately provide optimal care.

Comment #1

This is tragic. It makes me feel both heartbroken and furious. It certainly illustrates the unavoidable connection between societal structures and patients' wellbeing.

Comment #2

There is no right way to answer this question, but since it is a question that emerges from the realm of faith more than science, expressing uncertainty is reasonable. Even if you have a strong belief that there is no life beyond death, can be unequivocally assert this? Further, what is life? We are all stardust, right? And maybe that is the dust to which we return.

Comment #3

what a moving - although also I'm sure disconcerting - situation to have found yourself in. As you recognize, there are many social justice issues implicated in this patient's fate. I'm focusing on what an honor it was for him to ask you such a deep question. To me, this says a lot about the level of rapport and trust you established with him.

Sometimes it is worthwhile to consider, what is the question behind the question. I don't think what your patient needed or wanted was a theological debate. It seems more likely he wanted consolation and companionship. I do not ever advocate lying to a patient (yes, there is, if you don't believe that), but in this case I don't think your answer is important. What is important is the patient's feelings and fears, and by turning the question back on him in a kind, supportive manner, you give him a chance to express himself. It's also possible to probe. "You know you're very ill, and I can see you're thinking about your future. What are you worried about? What can we do to help you?" Maybe the patient would like to see a chaplain (maybe not). Maybe he'd like to communicate something to a loved one. His question opens up the possibility of still helping him even if you cannot secure the transplant he so richly deserves.

Comment #1

Interesting comment. I too am not sure what this means, and you did the right thing to try to elucidate its meaning. She is uncomfortable with the physical sensation of injections? She is uncomfortable with the image of herself as someone who needs insulin injections? She's afraid about what the need for insulin implies about her future? Until you have a better understanding of her concern, it's hard to proceed.

Comment #2

Interesting comment. I too am not sure what this means, and you did the right thing to try to elucidate its meaning. She is uncomfortable with the physical sensation of injections? She is uncomfortable with the image of herself as someone who needs insulin injections? She's afraid about what the need for insulin implies about her future? Until you have a better understanding of her concern, it's hard to proceed.

Comment #3

This essay illustrates the maxim, don't let the perfect be the enemy of the good. You can design an elegant treatment plan, but if the patient won't follow it, in the end it is worthless. In this case, you and your attending decided on a reasonable compromise. However, in the long-term this patient should be on insulin. Ideally, she could be desensitized to self-injection, but this is a function of adequate resources which are not always available to our patients.

The larger issue is the inability to practice optimal medicine. Sometimes this is truly impossible, but often with proper ancillary support staff and other resources, solutions do exist. It's just as a society we don't have the will to

*

Dear Katherine, this essay illustrates the maxim, don't let the perfect be the enemy of the good. You can design an elegant treatment plan, but if the patient won't follow it, in the end it is worthless. In this case, you and your attending decided on a reasonable compromise. However, in the long-term this patient should be on insulin. Ideally, she could be desensitized to self-injection, but this is a function of adequate resources which are not always available to our patients.

The larger issue is the inability to practice optimal medicine. Sometimes this is truly impossible, but often with proper ancillary support staff and other resources, solutions do exist. It's just as a society we don't have the will to implement them.

Comment #1

Impressive that the physician could assess this change over the phone - he must have had a very clear sense of how this patient normally behaved, and could use this as a baseline.

Comment #2

I understand both the physician's concern and the patient's defensive response. I'd be curious to know how the doctor presented the need for the immediate lab work. It would be important to express worry for the patient's wellbeing while avoid being accusatory or judgmental.

Comment #3

I too have seen and participated in both phone and video encounters, and agree that the visual component is very helpful. Phone alone can be unsatisfying and complicated except for very routine visits.

Comment #4

two aspects of this case are particularly striking to me: 1) How important it was that this physician knew his patient, so he could assess, even by phone, when the patient seemed to be acting very differently from his normal presentation. Especially given that the patient was taken a couple of potentially addictive substances, and the possibility that he might be self-medicating either with additional doses or other substances, there did seem cause for concern. 2) How difficult

telemedicine can be. As you point out, without even the video component, a telephone encounter can raise more questions than it answers. One problem is that neither patients nor physicians were prepared for telemedicine encounters - rather we were all thrown into it in the midst of a pandemic. I agree with you it has a lot of potential - for example, there is something "leveling" when the physician sees the patient in her own home rather than in the sterility of the clinic, which I think sets patients at ease, and makes them more likely to ask questions, disclose information, and generally have a conversation with the doctor - but it will take the development of new skills, expectations, and understanding on the part of both doctors and patients.

Comment #1

It says something important that she was able to voice her fear, which goes a long way toward explalining her "demanding" behavior

Comment #2

This is a very insightful observation. I wonder if you would agree that, in most cases, patient anxiety is not a DSM diagnosable disorder, but the natural reaction to a frightening development in the person's life and can be addressed with exploration and when appropriate reassurance. Of course, when the anxiety is as crippling as you describe, then the patient would certainly benefit from a mental health referral.

Comment #3

It sounds like you admired the physician because he was able to set limits and adapt to an evolving situation. I agree that these are both essential qualities in a good physician. I'm interested in your comment that the patient was dissatisfied with the encounter. Was this the sort of dissatisfaction that would lead her to seek care elsewhere? Or did it contain an element of acceptance of the physician's treatment plan?

Comment #4

your reflection makes a valuable point about the complex interaction of mental illness and other diseases, observing that the presence of psychiatric disorders can complicate both the doctor-patient relationship and an effective treatment plan.

Your comments about your FM attending highlight his ability to set boundaries, partner with the patient when possible, be flexible in his clinical approach, and find the proper balance between assertiveness and negotiation. You are absolutely right that these are all qualities that are essential

in the clinical setting; and the skilled physician must rely on a certain degree of "improvisation" to tailor her or his response to the specifics of the situation and the psychology of the patient.

Comment #1

I like the way you say "apparent," because how patients view their own health is a complicated experience mediated by life experience, family and culture, structural inequalities and many other factors. By probing beneath this "lack of concern" you will gain valuable insights in terms of how to care for this patient.

Comment #2

It is natural to feel frustration in any variety of circumstances; if you can make it a starting point for compassionate curiosity (what don't I understand about why the patient is behaving as he does?) rather than an ending point you will be able to deliver excellent care to patients who initially upset or irritate you.

Comment #3

you did great work here! First, in honestly noting your own frustration with the patient's uncommunicative interaction. Second, you challenged your own conclusion "lack of concern" by acknowledging that it was "apparent." Third, you spent time with the patient, eliciting his story, and understanding that, from his perspective, he was in a completely alien environment where he did not understand the rules of behavior. By entering a bit into his worldview, you were able to help him open up sufficiently to express the human fears and concerns we all feel about our health and mortality. The result was not only that the patient began to talk more openly with you, but that your own feelings of frustration were transmuted into compassion and caring.

On another note, I'm aware that you are one of the student organizers of a volunteer support program for residents and attendings to provide childcare, pet walks, and market runs. Bravo! The faculty in FM (and I'm sure other departments) are inspired and uplifted by this example. Thank you so much for caring about people on the front lines and for realizing that now more than ever you matter.

Comment #1

Very well-stated Krystal. You've defined the dilemma well: You do not want to go down rabbit holes driven by the patient's somatization; yet you don't want to miss a diagnosis because you're convinced there is no organic explanation for his symptoms.

Comment #2

An important aspect of such cases is to avoid sending the patient the message that you think it's "all in their head." These patients are used to be dismissed by physicians. Therefore, part of establishing a trusting relationship (necessary to effectively care for this patient) is showing that you take them seriously. This can be conveyed through an attentive conversation (check) and by letting them know that to work them up thoroughly you need reliable information from labs (check). Close follow-up also says to the patient that, rather than wanting to get rid of them, you are committed to seeing them on a regular basis.

Comment #3

You did an excellent job of identifying the Type I and Type II errors that the physician can make - do elaborate, expensive and sometimes dangerous workups in response to the patient's demands; assume there is nothing physically wrong with the patient.

It might have seemed odd that the doctor didn't just quickly jump into a workup that would lead to a differential diagnosis. But with patients like this, with a history of doctor-shopping, poor follow-through, and multiple complaints, most crucial is establishing trust so that possible psychological components can be adequately assessed. In fact, from what you describe, your attending was trying to break a dysfunctional pattern in which patient complains of constantly shifting problems, doctor makes referrals, patient doesn't pursue, and the cycle begins again. By establishing a human connection, the doctor is trying to lay groundwork to provide continuity care for this patient over the long-term.

Comment #1

Yes good point. In an initial encounter, you might defer to the sister's personal knowledge of the patient; while in later visits negotiate how actively the patient could be involved.

Comment #2

It is a shocking practice. It is also shocking to discover that in the early 1900s, as a result of the popular eugenics movement in the United States, many "feebleminded" women were sterilized often without their knowledge or consent. This practice continued in some form as late as the 1970s.

Comment #3

I can well understand your feelings, and you are correct that there are grave ethical issues implicated in this practice. However, time and place questions come into play in figuring out how or whether to address this issue with patient and sister.

Comment #4

your essay raises a horrifying ethical issue about forced unconsented sterilization practices for those deemed to have mental retardation. As I note, our own country has a shameful history in this regard.

Regarding how or whether concerns should be expressed to patient and family members, it is important to ask yourself what your goals are. I might want to first understand how the patient and her sister felt about the sterilization. Did the patient understand that she had had an operation so that she wouldn't have babies? Was she sad or happy about this? What was the sister's views? There is probably little value in having a philosophical debate on this issue. But I can envision scenarios in which not having this information might be detrimental to the patient, either emotionally or physically in terms of health history.

Bottom line, I commend you for not simply sliding over this piece of information, for thinking about its meaning and how it might be broached with patient and sister. I think it's a delicate situation that deserves careful thought, and a spontaneous expression of horror might do more damage than good. However, revisiting the topic with care and compassion might well be important for the patient's wellbeing.

Comment #1

I think you define the issue perfectly in your essay: healthcare professionals should try to accommodate patients' reasonable requests if possible (and religious and cultural objections to having male personnel examine a female patient fall under this heading); but this must not be prioritized over patient wellbeing. On several occasions I have seen physicians go to great trouble and personal inconvenience to try to provide a female physician for an exam or delivery, but sometimes this is not possible. Then, the team must be clear that their first priority is the health of the patient. Usually, patient and partner understand this. Occasionally, they will choose to leave to seek care elsewhere.

In the second instance, for me this is a good reminder not to make assumptions about people based on superficial characteristics. Simply because someone is Iranian does not necessarily mean that they will refuse a male doctor for a female patient. They may not be religious, or they may not endorse that specific prohibition. Always better to ask!

Comment #2

So the two of you had somewhat different agendas: You, appropriately, wanted to talk to her about her very complicated PMH. She wanted to recount the accident and the help she'd received. How could you reconcile or negotiate these?

Comment #3

Do you have any thoughts now about how you might have connected with her better? What do you think she needed from you?

Comment #4

This would certainly have been a good question that might have shed some light on her lack of follow-up with her specialists.

Comment #5

Yes, indeed, there is always pressure to be productive and efficient. In this case, you spent almost 40 minutes in a rather unfulfilling exchange, because each of you was pursuing a different agenda.

Comment #6

Great insight about FM - that's it exactly, a balancing act within a reasonable time frame while simultaneously establishing rapport and connecting with the patient.

Comment #7

I'm not surprised you struggled a bit with her. It sounds to me as though the interview was being pulled in two different directions - where the patient wanted it to go, and where you needed it to go. Neither of you was wrong, but you were not on the same page. Agreeing on the focus of a given encounter is essential in making it flow smoothly.

I wonder why the patient kept wanting to repeat the story of her fall. Sometimes people repeatedly talk about a trauma as a way of processing it. Perhaps this was the most interesting thing that had happened to her in a while, and had brought her the welcome help of strangers. For some reason, this story was important to her, and she yearned to have it acknowledged.

As you recognize, FM is all about setting priorities for a given visit, deciding what should be addressed, what can be addressed, and what will be left over for next time. On an initial intake, especially in the absence of a good HPI and PMH this can be confusing, even for experienced physicians. I think while you made a good start in untangling her complex medical situation, perhaps the lack of connection was a missing ingredient to a mutually satisfying encounter. Connection does not necessarily happen all at once, but sometimes can be facilitated by listening to the story people want to tell. The most important thing to me is that you persisted, you kept trying, you did not give up, and I suspect the patient appreciated your efforts.

Comemnt #1

Of course, it's always good to read the chart, but in a way it's also good to be ready for the unexpected every time you enter an exam room. The chart gives you the CC, but that may be just the tip of the iceberg.

Comment #2

Yes, this is pretty much the definition of privilege. The question becomes, what can we do with the privilege were were born with?

Comment #3

3rd year is very stressful and challenging, and it is easy to fall into resentment and self-pity (not always inappropriate by any means!). But I agree with you that the larger context is really gratitude for blessings given and received; and for the opportunity to serve others who have worse struggles.

Comment #1

It doesn't seem as though the patient is giving her doctors a chance to help. On the other hand, it's understandable that after years of using "creams" to no effect, another "cream" might trigger her frustration.

Comment #2

I think this latter point (about wanting to help her) might have been equally important as your medical explanations. When patients feel the physicians actually care about them, they are more likely to follow their advice.

Comment #3

it's always nice when there is a positive outcome. Given her long history of no results, the patient's initial reaction, though perhaps frustrating to doctors who were only trying to help her, was understandable. What I respected was the way her doctor and team stayed the course, patiently explained why this treatment was different even though it sounded the same, and importantly expressed their concern for the patient. You are absolutely right that when rapport and trust are lacking, it is harder to give the patient optimal care.

Comment #1

of course as you know, patients with opioid addiction are some of the most challenging patients to treat because they are driven by their addictions. No one likes to be manipulated, and no one likes to prescribe meds that may not be the ideal treatment for the patient. It is important to remember that the patient themselves in being "manipulated" by forces that they do not have much control over. These are very difficult situations to handle on an inpatient basis.

Fortunately, we have great specialists in addiction therapy in both Psychiatry (Dr. Nelson and Dr. Lunny) and Anesthesiology (Dr. Alem) as well as the neurobiology of addiction (Dr. Christine Fowler) who have developed humane, compassionate, and also limit-setting ways of working with addiction. I feel whenever possible these individuals or their colleagues should be consulted when patients with addiction are hospitalized. They can help avoid the frustrating conflicts that often arise between addicted patients and their providers.

Comment #1

What an interesting, and troubling, case. It sounds to me that not only was the patient in denial about her condition, so was her medical professional child! I can't help wondering if her "doctor daughter/son" had been open to a psychiatric diagnosis, would mom have been more receptive? Of course, mom is your patient, so she is the one primarily in need of persuasion. But you quickly realize in family medicine that often you are really dealing not just with an individual patient but with an entire family (and sometimes community!).

I was intrigued by your thinking regarding a hold. A 51-50 is rarely an ideal solution, but is clearly a necessary tool, regardless of the patient's age. Perhaps the patient's circumstances were such that

you felt she would be safe at home, despite her SI with plan. I'd be interested in learning more about what safeguards you were able to put in place for her. As you know, patient autonomy is a paramount ethical principle; but may be overridden if the patient is an immediate threat to self (or others).

Long-term, the keys to the patient's wellbeing may lie with the husband and adult children, whom she seems to trust. If they can be onboarded, she might become more amenable to psychiatric intervention.

Comment #1

An excellent step. As you see, there is the "rule," but in clinical medicine, each case is different, and sometimes the physician may decide that a family member is an acceptable interpreter in certain situations.

Comment #2

Acknowledging frustrations is always a good idea. Sometimes just sticking with the apology is more effective than trying to show them your perspective. Reassuring them that you are there to enhance their care and not slow down the process can sometimes help as well.

Comment #3

Excellent conclusion. You're adopting the patient's point of view and seeing things through his eyes. When you do this, you still might have a different perspective, but it makes you more empathetic and less frustrated yourself.

Comment #1

An excellent step. As you see, there is the "rule," but in clinical medicine, each case is different, and sometimes the physician may decide that a family member is an acceptable interpreter in certain situations.

Comment #2

Acknowledging frustrations is always a good idea. Sometimes just sticking with the apology is more effective than trying to show them your perspective. Reassuring them that you are there to enhance their care and not slow down the process can sometimes help as well.

Comment #3

Excellent conclusion. You're adopting the patient's point of view and seeing things through his eyes. When you do this, you still might have a different perspective, but it makes you more empathetic and less frustrated yourself.

Comment #4

you learned many valuable lessons from this encounter. One is that patients don't know the "protocol" that says it's better to use an official interpreter; and may feel more comfortable with a family member. This doesn't necessarily mean you should change the protocol, but it does mean you need to help them understand the reasons for what you're doing. A related point is that the way an educational institution operates are often opaque to patients. They don't necessarily understand the difference between a med student, an intern, a resident, a fellow, an attending. They just want a competent doctor to take care of them. Issues such as class and race and cultural difference often influence patients' perceptions of the quality of care they may be given. Many patients worry that they are not receiving the optimal level of care; and it is up to the providers to show them how hard we try to ensure they are cared for properly.

I endorse your conclusion not to take things personally. It is always valuable to reflect on whether, in fact, you HAVE contributed to a misunderstanding, because then you have an opportunity to learn something. But often a patient's response has little to do with you and is more an expression of their own fears, anxieties, and distrust. Understood from this context, their responses are easier to address.

I really admired the empathy exercise you engaged in at the conclusion of your essay. It can be difficult to take the time to try to understand the patient's perspective, but it is always worthwhile; and can give you valuable tools to help get an interview back on track, improve adherence, or simply earn a patient's trust.

Comment #1

Caution is a good quality if it implies openness to whatever lies behind the exam room door. Assumptions and defensiveness are what we want to avoid in patient encounters.

Comment #2

This is also an important observation. A patient's presenting problem may be diabetes, or flu, or HBP. But you always want to assess whether there are bigger problems that need to be addressed, as in this case.

Comment #3

you did an excellent job of being able to see this patient's humanity and suffering. It is essential to keep that context, which of course is the only context that should exist in medicine, yet somehow is all to easily forgotten. Especially in encounters with patients struggling with addiction, it's easy to become frustrated with them, or blame them for their behavior. While you need to know how to set limits and not collude with behavior that feels - and may well be - efforts to manipulate you, the critical thing to remember is that the patient is in pain and trying to address that pain the best they can. Sometimes you have to believe in patients when they no longer believe in themselves. This does not mean being naive about the powerful needs created by addiction, but it does mean never forgetting the patient's humanity.

Comment #1

Good awareness, Matt. You can draw on your own cultural background to help you connect with your Latinx patients; but you also want to be aware of differences in attitudes, expectations, belief - and yes, food! - that might lead you to make erroneous assumptions.

Comment #2

I agree, but good for you for trying. And yes, trying to figure out what the patient cares about and what they're willing to do is more likely to lead to a successful outcome.

Comment #3

I appreciated this reflection on how even an apparently simple thing like food is so deeply rooted in culture, and therefore so hard to change. I really liked the little cognitive experiment you performed on yourself - "What it would be like if I was told to give up rice?" Using MI and having empathy for the enormity of what you're asking leads to more realistic solutions where you support the patient in guiding their own care. This approach is more likely to lead to successful outcomes in the long-term. And yes, of course you are right, people's cultural orientation influences their reactions to healthcare recommendations and interventions. As you wisely say, the more you can understand about your

patients' beliefs, values, expectations, the more you will be able to shape the encounter to match their needs.

Comment #1

I know you are all trained to always used a formal interpreter through the iPad or other device; but in point of fact patients sometimes resist this when a family member is available. There are pros, but also a lot of cons, to using a family member. It's interesting that in this case your patient insisted on a female physician but was comfortable with her son translating personal aspects bout her health.

Comment #2

This is a really important question. I'd like to hear your further thoughts on this issue. In general, we try to accommodate requests that respect a person's religion or culture; but we draw a line at requests that are racist in nature. Twenty years ago physicians rolled their eyes when Muslim women requested a female ob-gyn for a delivery; but now these requests are regarded as routine and honored whenever possible. However, the last clause is important because occasionally, for example in a small hospital or an emergent situation, it is not possible to accede to the patient's wishes; and of course there have been instances of patients leaving hospitals AMA because their desire for a specifically gendered doctor could not be met. There are many philosophical and moral questions involved in this issue.

Comment #3

If doctors believe the request is reasonable, care should not be affected. When physicians regard requests as unreasonable, their exasperation and judgment may indeed subtly alter the quality of care. But, per above, these perceptions can change.

Comment #4

you grasped instantly the moral, philosophical, and practical implications of patients' expressing preference for certain kinds of physicians. We now easily (usually) adapt to requests for a female physician by female patients (especially Muslim women, because it is seen as accommodating their religion and culture). This is all to the good.

But think of other possibilities: a male patient wanting to be seen only by female physicians - that would raise eyebrows and likely would not be accommodated. Or a racist patient refusing to be seen by a Black physician?

That is an instance where, morally, I personally think it is wrong to accommodate the patient, but I have seen physicians remove themselves from a case because of a patient's racist request. These physicians feel that it is not their job to educate racist patients; and further, that they will not be able to provide optimal care to the patient (patient will be mistrustful, uncooperative, nonadherent etc.) and they may have a point.

I hope we can discuss this important issue further in class.

Comment #1

really try hard to avoid badmouthing other physicians. It forces the patient to choose between a doctor they've trusted and a stranger. Almost always they'll stick with what is known. A better way is to simply outline the efficacy of your (better) approach and what it will do for the patient.

Comment #2

These were both good ideas, because they convey that the doctor is not simply going to criticize the other physician, but is willing to try to help the patient and address her problem.

Comment #3

Yes, it's a hard situation because the patient's life experience for many years is that she knows what works for her body; and how she has to trust a strange doctor telling her that it really isn't good for her. The patient is more likely to come back if she feels the doctor is concerned for her wellbeing and is really eager to help her.

Comment #4

this is a difficult situation where the patient probably is addicted to Ambien and it will be hard to wean her. Some doctors in an initial visit will provide a single prescription with the understanding that the goal is to switch to a different method of treatment. Others, like this physician, will refuse the prescription entirely. If they work hard to show the patient they are not blaming her for her dependence on Ambien, and demonstrate a willingness to seek safer alternatives the patient may return. As you say, time will tell. It is all about whether the doctor has been successful in persuading a reluctant patient that there is a better way to help her with her sleep problem. The best way to accomplish this is through lots of empathy, understanding, nonjudgmentalness, and a plan going forward that seems likely to be effective.

Comment #1

You've defined very well one of the leading challenges of family medicine, where patients typically have multiple complaints, often have psychological issues as well, and for both financial and convenience issues hope to deal with everything in a single visit!

Comment #2

So this probably took a long time, but I am impressed with the thoroughness of your interview, how much ground you covered, and how you were able to get your patient to open up about her stress and anxiety. It is very hard to do these things, so I hope you give yourself credit for how well you did.

Comment #3

And this is why continuity care is important. These problems cannot all be addressed in a single visit, much less resolved. So you are trying to figure out what is most important at this moment which is either an acute physical problem (like a heart attack or soaring blood pressure, which is usually not the case) or mental health crisis (suicidal ideation, hallucinations etc.)

Comment #4

This is quite true - but perhaps surprisingly just listening to patients and confirming that, under the circumstances, their distress is normal and understandable, can be very helpful. If they are in crisis, you can then make a referral, but sometimes just listening to their story and providing validation is a big help. The clinic also has in-house resources that can provide support.

Comment #5

You learned two core principles that lie at the heart of primary care and especially family medicine. 1) Set priorities - what is the most pressing problem at the moment? Then start there 2) Try to make things a little better rather than "solving" or "fixing." Of course, some problems can be fairly easily solved - prescribe an antibiotic for a strep throat, splint a broken toe - but in primary care, many problems such as musculoskeletal complaints, diabetes, hypertension etc. - need to be managed over time rather than completely cured. Thus it's important for both patient and doctor to learn how to be satisfied and pleased with incremental progress.

Comment #1

We can learn many lessons from this unfortunate story, but it certainly drives home the awareness that, when people are sick, they are extremely vulnerable; and what happens during this time can have long-lasting consequences.

Comment #2

This is a terrible consequence of our country's long history of racism. It is not of much comfort, but at least the patient was able to acknowledge this point openly; and you and your team were able to affirm and support his perception.

Comment #3

Yes, and so glad that you and the attending both realized this. With BIPOC patients, it is important to factor in, with sorrow, that intergenerational trauma may well play a role in the patient's emotional state.

Comment #4

It is often a good approach to surface uncomfortable issues, rather than pretend they don't exist. I also think there is much to be said for making referrals to therapists with particular background and training to respect and address the patient's experience. (There is research suggesting that patients, especially psych patients, feel more comfortable with someone who shares their own background and, if appropriate, their language). Of course, it is important to do so in a way that does not dismiss the patient or his concerns (to imply, in some way, that his problems have nothing to do with you because you have the privilege of not experiencing them). Rather, in my view, it is sending the message that you will help him find the expert support he needs (and it can be hard to find a Black male therapist), while continuing to be his medical team if he is comfortable with that.

Comment #1

First, I applaud your recognition of the sub-text of this encounter; and your courage in surfacing it. These are the kinds of conversations that we have too infrequently. Yet their absence leads to a kind of dishonesty and falseness which everyone feels, and creates an environment in which it is hard to establish trust. So good for you by making explicit what was unsaid but very much present.

Secondly, the issue of racial/ethnic matching is an interesting one. As I note, there is plenty of anecdotal evidence and some research evidence as well that patients feel more comfortable with physicians of similar backgrounds because they feel they will be better understood. However, because of structural inequities, it can be hard to consistently find therapists or other health professionals that "match" the patient. Further, there are many factors that make a good therapeutic match, race/ethnicity being a very important one, but not the only one.

Finally, while you are absolutely correct that your relative privilege has provided you with some insulation from the injustices that this patient has experienced, we want to avoid giving a patient the impression that we can't care for them because we don't understand their problems. It is a thorny issue, but in my mind you want to strike a balance between finding the resources that will be most helpful to the patient, while not conveying the sense that you can't care for them because you can't "understand" them. Rather, humility in the face of the patient's story and openness to appreciating the patient's perspective can make you an important part of his team.

I really appreciate your awareness of how structural racism and inequalities affect the interaction between doctor and patient in the clinical setting. The exam room is not exempt from the forces that shape our larger society; and the more you can acknowledge that overtly, as you did so beautifully, I think patients will feel less inadvertently gaslighted by the healthcare system, and safer in seeking care.

Comment #1

The GAD7 was an excellent idea, and it certainly sounds as though anxiety was at least a component. We also have to be on guard against becoming too attached to our diagnoses, and discount disconfirming evidence. In addition to anxiety, I wonder what else was going on in his life that might make him stressed or anxious.

Comment #2

This is an important insight. EVERYONE, including both patients and physicians (and often family members as well) need to be "satisfied" with the explanation. Often this happens seamlessly, but other times it can be a painstaking and frustrating process.

Comment #3

Although certainly very frustrating. It sounds like you realized that in such situations, while you can give reassurance (thank goodness our tests show you don't have cancer), you want to avoid discounting the patient's pain and suffering. In other words, it's important to confirm the patient's distress, regardless of how subjective this might be. Further, as you know, sometimes patients express their misery somatically when they have trouble verbalizing it. The patient may well have an anxiety disorder that is contributing to his somatization; and there may also be circumstances in his

life that are causing him to feel ill. Sometimes probing the broader life story can illuminate a litany of symptoms.

Comment #1

Yes, it is a real dilemma. Science cannot always effectively argue with faith. Sometimes enlisting an intermediary, such as the hospital chaplain, can help patients/family members accept a perspective in which God and science work together.

Comment #2

I appreciate your sensitivity to this quandary and your compassion for the struggles of this family. When faith and science end up on opposite sides of an issue, it can be hard to reconcile the two. You and the team made a very good start by listening carefully to the parents' perspective and treating their beliefs with respect. Your goal is to help them be able to accept that God and science can work hand in hand, and that may include enduring the trauma of the G-tube.

I also suspect that the parents may just not be ready to acknowledge that their daughter's situation is deteriorating. Working through social work to find help for the family (possibly through their church), and listening to their struggles as you did might help prepare them to be able to do what their child needs medically.

Comment #1

I appreciate the way you reflected on this frustrating interaction. As you did, it is always helpful to consider a) what might the patient be contributing to the difficult interaction, and why? b) what might I (provider) be contributing, and why? c) what might the system be contributing and can it be fixed?

In this case, the patient was in distress and, as you note, perhaps not in the best mood to talk to a medical student. Related to this on a systemic level, if a nurse or MA had made an initial inquiry, the patient's resistance to being questioned by a medical student could have been elicited quickly and the encounter could have been avoided. So this was a creative and innovative suggestion on your part.

Finally, I find I always learn something from difficult interactions. Did the patient's frustration with me create a kind of mirror frustration in me toward her? I've found that sometimes if I center myself so that I am calm and not reverberating to the patient's emotional upset, if I come from a respectfully curious place rather than a defensive place, the interaction settles down and can go forward - and sometimes not! Sometimes helping the patient understand your role on the team and how talking to you can provide a more efficient and deeper visit with their doctor can convince them it's worthwhile to talk with you - and sometimes not! There is no one right way to handle such situations.

Comment #1

Language and cultural differences can present challenging barriers to expressing understanding and support, even when the provider might be feeling them.

Comment #2

I was intrigued by your perceptive comment that you might have phrased your questions differently. Clearly you were making every effort to be caring and concerned. I think you offered a hint when you wrote, "sometimes simpler is better." The rules for an interpreted interview are somewhat different than a language-concordant exchange. Indeed, questions that are direct and simple have a better chance of emerging unscathed via translation; and a better chance of being accurately understood by the patient.

As you no doubt realized, when there is no shared language, nonverbal behavior, such as tone of voice, body language, and eye movement (mouth is less important now that everyone is masked) become even more important. Bottom line, you understand how important to create an atmosphere of trust and safety, especially across cultures. Learning how to build that will develop over time, so long as you have the desire and intention to do so.

Comment #1

Really good questions. This is exactly the right response - don't blame the patient for his mood and behavior, but go for understanding. What is causing this reversal?

Comment #2

Exactly right. What is important to the patient always deserves respect and attention. It is not necessarily the end of a conversation, but rather hopefully the beginning of one. Sometimes a patient's immediate need for comfort or familiarity may cause them to make short-term decisions that are not aligned with their long-term desires. So the patient's priorities at times deserve to be interrogated (as do the physician's!), I think where the problem arises is when doctors assume their priorities are the correct ones.

Comment #3

I really appreciated your essay, and especially the way you are an advocate for your patient. I also respect your awareness that physician and patient priorities do not always align, and this does not mean the patient is always wrong. Sometimes it is the physician who should adapt. In the case you describe, it sounds to me as though there is no medical reason why the patient could not leave and do the diagnostic work-up as an outpatient. This might have been more inconvenient for the VA system, but not an impossible request, and one that the physician could work with.

If on the other hand, the patient was saying, I do not want to evaluate this highly suspicious esophageal mass, then that needs to lead to further conversation. When the patient's priority is avoiding terrifying news, that should be heard and treated respectfully, but not necessarily accepted until it is clear that it is a decision driven by thoughtful interrogation of one's own values, beliefs and life philosophy etc., rather than by momentary emotions. However, in the long run, it is the patient's priorities and preferences that must prevail. The role of the physician is not to "tell the patient what to do" but to ensure so far as possible that the patient is making the choice that aligns best with their most deeply held convictions.

Comment #1

Very informative answer. You were, as you shared with him, under the gun of your bosses to get the answers to certain questions in a timely fashion. That was your agenda. The patient's agenda was to be left alone. Hard to reconcile those. But as you can see, the patient can have great negative power. Perhaps if you'd asked him earlier what he needed from you, he would have been able to share that he needed space, and you in turn could have negotiated this with your superior.

Comment #2

of course a big complicating factor in developing a good doctor-patient relationship is psychosis! Still, I think there were some valuable lessons that could generalize to other situations. For example, you tried different strategies for reaching the patient. One was where you shifted the power dynamic by portraying yourself as vulnerable to your superior, rather than as the authority figure; and that seemed to help a bit.

The other thing you did that I admire was that, after his psychosis cleared, you asked the patient directly what you could have done differently. In fact, you learned that the patient wanted more space. This might have been difficult to achieve, but if you had this information early on, you could have problem-solved a more tailored approach with your attending. When you have a big elephant in the room that is sitting on top of what you're trying to accomplish, it makes sense to figure out how to move it :-)

Comment #1

Absolutely. These are complex issues and likely hard to resolve in a few minutes.

Comment #2

all your observations are really right-on. Since you realize that this patient's issues cannot likely be resolved in a single visit, what would your goals be for this initial encounter? What groundwork would you want to lay to raise the likelihood that the patient will return? For example, you don't want to argue with the patient about whether he has a psychiatric condition. You do want to emphasize how normal and understandable it would be to feel some anxiety about physical symptoms based on his traumatic past. What I liked so much about the proposed plan is that it addressed his physical issues but didn't neglect his psychological history. I agree with you and your attending that the challenge will be to get him to buy into this model. The approach (which you also took) of emphasizing that trauma has real physiological effects on the body seems as though it might hold promise, as it may be a way for him to understand his symptoms as not "all in his head." Your conclusion is correct. This patient needs to build trust, which takes time and a willingness to address what he sees as his problems, while not letting go of the bigger picture. For example, you don't want to argue with the patient about whether he has a psychiatric condition. You do want to emphasize how normal and understandable it would be to feel some anxiety about physical symptoms based on his traumatic past. What I liked so much about the proposed plan is that it

addressed his physical issues but didn't neglect his psychological history. I agree with you and your attending that the challenge will be to get him to buy into this model. The approach (which you also took) of emphasizing that trauma has real physiological effects on the body seems as though it might hold promise, as it may be a way for him to understand his symptoms as not "all in his head." Your conclusion is correct. This patient needs to build trust, which takes time and a willingness to address what he sees as his problems, while not letting go of the bigger picture.

Comment #1

I like the way you reflected further on your initial reaction to your patient's behavior. It seems you came to a deeper understanding of her motives in making these statements.

Comment #2

I wonder in a situation where the patient not only wanted her husband included, but wanted to defer to him entirely in terms of the actual decision-making (e.g., deciding about the use of birth control), how you might proceed.

Comment #3

I like the way you interrogated your own expectations and assumptions for this patient. Cultural practices can play a significant role in the way patients interact with health and illness. It is also true that disrupting traditional ways of functioning is rarely successful, and often has a cultural imperialism flavor, no mattter how unintended ("I know better than you how you should live").

That said, it is also important to try to determine your patient's true desires. For example, many women from more male-dominated cultures have ambivalent feelings about their submission to fathers, husbands etc. Again, using the example of birth control, when alone with her physician, a woman may express the desire for the very birth control her husband has vetoed. In these circumstances, your priority is to ensure your patient's safety (in case the husband might be prone to violence), to help her understand the consequences of her choice, and then to support her decision.

I agree with you wholeheartedly that clinical medicine is partly about the biomedicine, but it is also very much about the people, families, cultures, and societies in which those people are embedded. Treading lightly and with respect is essential in medical practice.

Comment #1

Okay, no magic bullet, but this is a good strategy - i.e., try to show the patient the benefit to them. I've seen it be succecessful, but it doesn't always work.

Comment #2

That's an interesting observation - I wonder wny this is so? The patient is not as intimidated by you, the student? Or feels there's less at stake?

Comment #3

I agree, both with your observation that many chronic pain patients adopt a rather demanding attitude; and that it is difficult to know how to respond.

Comment #4

you make a really insightful observation about the way interactions tend to go with chronic pain patients. True, many if not most of these patients may have organic pain. It is also true that, because of the nature of opioids, they are at risk for abusing their prescribed medication. How can you set prescribing limits so that you are not colluding with the patient and perhaps causing harm; while at the same time remaining caring and compassionate to their suffering? Especially when they are hostile, pushy, and rude?

I think understanding what lies beneath their behavior can help us stay calm and not resentful. Of course, these patients are in pain, are suffering, and they are fearful the only way they know to ease their pain will be denied them. Remembering that they are frightened and in distress does not mean the physician should prescribe opiates inappropriately. But it can help in setting appropriate limits, offering other alternatives, and reassuring the patient that your goal is to provide her with the best possible care. In a continuity patient, if the behavior you describe is characteristic, at some point I would also consider talking to the patient about it, so that she is aware that her demandingness only makes it harder to care for her. Param, you make a really insightful observation about the way interactions tend to go with chronic pain patients. True, many if not most of these patients may have organic pain. It is also true that, because of the nature of opioids, they are at risk for abusing their prescribed medication. How can you set prescribing limits so that you are not colluding with the patient and perhaps causing harm; while at the same time remaining caring and compassionate to their suffering? Especially when they are hostile, pushy, and rude?

I think understanding what lies beneath their behavior can help us stay calm and not resentful. Of course, these patients are in pain, are suffering, and they are fearful the only way they know to ease their pain will be denied them. Remembering that they are frightened and in distress does not mean the physician should prescribe opiates inappropriately. But it can help in setting appropriate limits, offering other alternatives, and reassuring the patient that your goal is to provide her with the best possible care. In a continuity patient, if the behavior you describe is characteristic, at some point I would also consider talking to the patient about it, so that she is aware that her demandingness only makes it harder to care for her.

Comment #1

I agree, many physicians would adopt exactly this approach, more's the pity, and for exactly the reasons you ascribe to them.

Comment #2

As Osler wisely said, it is more important to know which patient has the disease, than which disease the patient has.

Comment #3

Yes, and each of these differences will affect how these patients respond to treatment recommendations, as you realize so well.

Comment #4

It's great that you've seen in action the power of listening to and considering the patient's life circumstances in delivering care.

Comment #5

This is a very humane and insightful essay. I appreciated your observation that you've actually seen patients improve when doctors consider their social context in developing a treatment plan. The purely biomedical approach you reference at the outset of your essay seems to be efficient and effective, but it often falls flat because it is a one-size-fits-all and not tailored to the specific life situation of the patient. Further, by eliciting the patient's story, you convey that you are interested in them as a person and what will happen to them, thus engendering trust, which in turn makes the patient ore likely to buy in to a treatment plan. I really think that a patient-centered approach can be fiscally profitable as in the long run it will actually lead to better outcomes.

Comment #1

this is a terrific essay. I appreciate your critique of the tough love approach, especially the insight tht it exploits the power differential between doctor and patient. I agree that MI is usually a more effective approach. It is certainly more respectful. Your last line is key - "perhaps the patient could come to her own conclusion..." In such important life decisions, the patient needs to buy in. The physician is there to inform, support, and guide.

The interesting question becomes, why do so many doctors persist with the fear-based, "telling" approach. Partly time is a factor (MI can take a while, although there are many abbreviated models that are also useful). But, as you perspicaciously observe, part of the reluctance may have to do with relinquishing power and control, which is a safe space for many physicians.

Thank you for your thoughts.

Comment #1

This is a difficult belief to respond to. On the one hand, it may put the life of your patient in danger. On the other hand, you need to be careful about challenging her theological convictions or run the risk of losing her entirely as a patient.

Comment #2

I actually think this is a very creative approach. You are working within her belief system, which is a good thing. Of course, you want to offer such an alternative explanation with as much humility as possible: "You know, the way I look at it...."

Comment #3

Excellent concern. This is why personally I would avoid constructions like "This is what God wants," and be tentative and humble: "It might be that God wants you to..." This way you are offering another way of thinking about the situation that might be consonant with their belief framework; but you are not manipulating or coercing them. If we're honest, medicine is a lot about persuasion, and you just have to sort through when you use rhetorical techniques to be as clean as possible about your motives and goals.

Comment #4

this is an exceptionally thoughtful and perceptive essay. Thank you! Your worry about "manipulating" your patient into taking more charge of her own health is an ethically nuanced position. In my view, you reconceptualized the issue in a way that used language and beliefs familiar to the patient to offer her another perspective. It sounded to me you did so in a sensitive and respectful manner; and that she had the right to disagree with you. In fact, sometimes when a patient is resistant to a course of treatment and cannot be persuaded otherwise by the physician, it is even worth considering having them consult with a respected religious figure in their community who might help them see that the proposed approach does not violate their religious convictions. In any case, I hope we get to discuss this issue in class, it is a fascinating and very worthwhile one.

Comment #1

you are a good writer, and I enjoyed the way you told this story. Of course, as you know, bias does not mean shying away from a diagnosis or ignoring aspects of a patient's behavior; but rather approaching these diagnoses and behaviors with a nonjudgmental, compassionate attitude.

This sounded like a perfect situation for MI. You are not going to change alcohol addiction in a single visit, but this is a good way to begin to understand the patient and the factors involved in his drinking. In my book, you accomplished something important simply by getting him to acknowledge his own drinking, rather than you telling him and him denying.

I love that you call yourself "a healer in training" - this is a wonderful aspirational role for you, and all medical students and physicians! I think you handled this situation beautifully and perhaps even laid the groundwork for appropriate intervention with this patient.

Comment #1

This is such an interesting comment. I think it speaks to the assumptions or stereotypes we all hold in our minds about who "believes in science," who trusts their doctors, and who is adherent to prescribed treatment plans.

Comment #2

I wonder if you were feeling upset or frustrated with this patient because he has all this privilege, all these advantages, and chooses not to use them for his own wellbeing. If this is the case, how do you think those feelings might affect your interactions; and how might you turn them to the patient's benefit?

Comment #3

I wonder if you were feeling upset or frustrated with this patient because he has all this privilege, all these advantages, and chooses not to use them for his own wellbeing. If this is the case, how do you think those feelings might affect your interactions; and how might you turn them to the patient's benefit?

Comment #4

Yes, apparently he does not see the benefits, and this becomes the key issue - why? What are the assumptions, beliefs that fuel his skepticism?

Comment #5

Very well-stated. Your upsetness/irritation etc. with this kind of patient can make you cynical and disillusioned, which can certainly lead to bunr-out.

Comment #6

Yes, of course, especially as a medical student, stepping out can be a valuable option to recenter. However, the issue of treating patients toward whom we have judgment or feel dislike is a very interesting one, and worth exploring further so that, when you can't leave the room, you have some strategies for how to be an effective physician for these patients as well.

Comment #7

It is great to recognize strong emotions you may have in any given clinical situation; and sometimes it is very helpful to step out a the room temporarily just to take some breaths and center yourself.

At some point, however, you may want to explore the kinds of feelings you had in response to this particular patient. Hopefully, you will choose a practice environment in which you will be able to serve more underresourced and in-need patients, and thus avoid the sort of entitlement this patient demonstrated.

However, you will also inevitably find yourself in clinical situations that involve patients similar to this person, or other kinds of patients who trigger your judgment. Then you will want to figure out how you can best participate in their care, which as you point out so well, all patients deserve.

As you insightfully realize, all of us have implicit bias, and the key is to be aware of it and figure out strategies for mitigating it. I think often the key is finding a way to be genuinely interested in the patient, what has led them to the views they espouse. This does not of course mean you endorse or agree with them, only that you are willing to hear their story.

Comment #1

This is completely understandable, Ruchi. But these tears and the patient's ability to verbalize her fears is also a great gift, because now you know what is the most important issue to address in the encounter.

Comment #2

You do a great job of understanding where this patient's fears are coming from. Fortunately, you also have information that can reassure her.

Comment #3

This too is very understandable, and is completely expected as a beginning third year. If I had to choose, erring on the side of listening and compassion is the better "mistake" to make than focusing solely on efficiency and time management. I know you will learn the balance as you become more proficient with dealing with the kinds of obstacles you ran into in this encounter.

Comment #4

Yes, this is key. Listen for the patient's most critical priority, and address it. Patients can accept limits if you set them with respect and caring.

Comment #5

Also a great insight. Learning to be able to roll with the punches, to improvise, without becoming panicked or paralyzed because things are not going according to plan, is one of the most important contextual skills of a good clinician.

Comment #6

Thank you for this insightful and honest essay. You had to deal with a lot of unexpected difficulties at once. As you realized, welcome to clinical medicine! This is par for the course, and it's important to develop the cognitive and emotional flexibility to adapt to changing clinical circumstances.

You also struggled - appropriately - with the tension between unlimited compassion and the need to be efficient and productive. Finding that balance is another challenge of clinical practice. In my view, you made the right call. You listened carefully to your patient, and recognized that the most important issue in that exam room was reassuring her that having diabetes didn't necessarily mean she was about to lose her feet. Responding with compassion and concern to what the patient cares most about ensures that you will build trust and that you will be able to meaningfully care for this patient in future encounters.

Too often in medicine the priority is to get things done - get patients diagnosed and treated, in and out. These are things easily documented. But if a patient feels they were not heard or treated without respect, even though the encounter may have concluded in a timely manner, you may never see that patient again; or they may hesitate to follow your treatment plan; or a myriad other consequences.

You will see plenty of physician role models who demonstrate how to practice genuine caring with efficient time management. It really can be both, not one versus the other.

Comment #1

These are always difficult situations. The physician is on the alert for drug-seeking or drug-dependency; while the patient often legitimately knows her diagnosis and the medications she needs. I am not a physician, but I know there are other medications besides Xanax that are used in the treatment of TN.

Comment #2

This is an excellent point. In any case, you would want some treatment plan in place that weaned the patient appropriately from her Xanax.

Comment #3

you've done an excellent job of delineating the problem. The physician is concerned about abuse of controlled substance. The patient wants to continue the treatment plan that has stabilized her incredibly painful situation. How can both goals best be achieved? While it is valuable for the physician to clearly state his medication philosophy, it is also important to convey to the patient that he understands how upsetting and frightening this situation must be for the patient. In addition to referral, ideally there would be a commitment to being her pcp (since her insurance no longer covers her old pcp). As such, he should convey his absolute commitment to assisting her in pain management and findings answers for her suffering. Then perhaps a short-term continuation of her current medications while other more optimal solutions are pursued might be less threatening and more effective.

Comment #1

this is a really fascinating account, and indeed represents "bread and butter" family medicine. Your conclusions are absolutely correct: 1) without "motivation," (which includes belief in self-efficacy), no matter how much information the physician provides, the patient will not be able to act on it 2) motivation is a complex phenomenon, and can be positively influenced by the awareness that someone (in this case the physician or medical student) actually cares about them. A doctor cannot compel a patient to change; but by creating a sense that they are a team, they can help the patient have the courage to take responsibility for their own self-care.

I don't know what inspired you to show the patient caring and empathy, but this was absolutely the right approach. Transmission of knowledge ("patient education") can of course be helpful and can change people's behavior. But it is only one piece of a complex puzzle. Empathy and caring are important pieces as well.

Comment #1

Although it takes more time, this is a valuable step. When you learn the "why," you may discover misconceptions or assumptions that can be corrected, resulting in greater receptivity to inoculation on the patient's part.

Comment #2

Excellent observation. Asking why often puts people on the defensive, making them feel they have to justify their position. Instead, you can say, "I respect this. Can you help me understand how you came to this decision?"

Comment #3

Excellent point. The medical perspective is only one of many, and not universally shared. JW adherents often risk death because they believe transfusion can endanger their immortal souls. Simply scoffing or attempting to override patients' beliefs simply results in alienation and closes the door on continued dialogue.

Comment #4

Absolutely a superb insight. Anger puts you and your patient on opposite sides; whereas understanding and respect create connection and the possibility of future alliance.

Comment #5

, I really liked how you handled this situation. It is easy (and understandable) to become exasperated with a point of view that makes no logical sense to you, especially when health and sometimes life itself is at stake. However, from both a moral and pragmatic perspective, listening to the patient and seeking understanding of their viewpoint is a better way forward. Getting upset with patients will alienate them; treating them with interest and respect earns their trust, even if you cannot come to agreement (as happened in this case). For patients, many things can supersede medical concerns, such as day-to-day survival or as here religious concerns.

I especially appreciated the point you made that listening to patients is not only good for the patient, but it is also good for the doctor, helping them to enjoy and take interest in the practice of medicine and to avoid or ameliorate burn-out. An excellent and accurate observation!

Comment #1

Wow, it sounds as though this man truly had worked through an amazing number of issues. Yet your attending's concern is not misplaced. What you are trying to discern is a very complex view into someone's heart and mind.

Comment #2

What an excellent commitment. Exactly - you are the facilitator and guide, not the director.

Comment #3

the phenomenon of de-transition (which frankly I know little about) is a complex one. I know there can be a lot of judgment against this decision, a sense that it is a betrayal of the trans community. As you show in your essay, the situation is probably a lot more nuanced. In some cases, people do choose to de-transition because they are fearful of the burdens that being a trans person in a still punishing and condemning society may be too much to bear. It is also possible, as with the patient you describe, that they come to a different, yet still authentic conclusion, about what is right for themselves as they begin the process.

It is incredibly hard to sort out these different threads. In the end, in my mind, you've got it exactly right. Your role as the physician is to support your patient's genuine wishes as best you can; and to crate a safe space where those issues can emerge. This involves, as you note, listening deeply, attentively, and nonjudgmentally, encouraging the patient to examine fears and blind spots. In the end, trust your patient.

Your concluding line is poetry; and sometimes poetry provides a better answer than science.

Comment #1

Yes, it is culture shock for you, the medical student, because now you are trying to practice all you've learned in an unfamiliar environment without the landmarks of language, expectations, and beliefs that you're accustomed to. Good insight.

Comment #2

It sounds as though you thought the drug was the best option for patient and family, is that right?

Comment #3

Great insight! What's key here is, of course, trying to figure out what's in the best interests of the patient, given his AND in this case, the family's values and priorities. Your personal beliefs in this case may be based on information and knowledge that might offer a better option for the patient. Or it might be a toss-up, in which case the family's values and preferences should prevail.

Comment #4

You raise a couple of really interesting issues. One, I think, is how difficult it can be to be the best doctor you can be when you don't share a language and certain cultural assumptions with your patients. You suddenly find yourself a stranger in a strange land! This is really challenging, and I wonder how you tried to overcome these obstacles, and how you feel your doctoring was affected.

The second issue is when patient/family disagree about recommended treatment. In this case, everyone agrees that the patient's behavior needs to be better managed. The only question is how. Without more information, I can't evaluate the severity of the behavior, the risks of the medication or the likelihood that the fmaily has access to behavior therapy and its likely efficacy. But in such a situation, these are the factors that you would want to weigh, as well as, of course, the family's preferred method of treatment, to which they would likely be more adherent. It is also possible that some combination of drug and non-drug approaches might be most useful, so that a lower dose of the drug could be used; and eventually the patient could be weaned off having simultaneously mastered behavioral management skills.

You are absolutely correct that we should always have respect for the patient's viewpoint, ESPECIALLY when it differs from our own, and make every effort to understand the thinking and feeling that underlie it. This is the necessary starting point for a dialogue or negotiation with the patient in which your perspective as the physician/medical student and the patient's/family's perspective are hopefully reconciled into a coherent treatment plan acceptable to all parties.

Comment #1

The is an interesting and complex issue. My view is that it is worth engaging with maskless patients in an attempt to influence their thinking. Needless to say, this must be done respectfully and nonconfrontationally, not blaming and shaming, but based on curiosity and concern for the patient's welfare and those they love (not necessarily people in general, whom too many don't seem to care about at all). Masks are one of our few reliable forms of defense and especially with the frustratingly slow and inconsistent roll-out of the vaccines, and the emergence of new coronavirus mutations, I feel it's a physician's responsibility to at least raise the question.

Comment #2

Wow, I haven't heard one before and I thought I'd heard it all. Good for you for doing the research to understand the mom's perspective. I hadn't realized the involvement of immortal fetal cell lines. Of

course, this is not the equivalent of "dead babies," but if you had simply dismissed her claim as ridiculous, she would simply dismiss you as another uninformed physician who doesn't know the "real story."

Comment #3

It is very true that some people's views, especially anti-vaxxers, are so strongly held and their trust in science and physicians so weak that it is usually impossible to change them. In this case, it's interesting that the mother was willing to accept other immunizations while rejecting the flu vaccine. To me this suggests that, if a continuity relationship could be established, over time it might be possible to build on the mom's concern for her children's welfare to promote the use of the flu (and eventually the covid!) vaccine.

Comment #4

Yes, it is especially frustrating when children have no choice but to conform to the distorted beliefs of their parents. I'm sure you're aware of a movement of minors and young adults who were raised in anti-vax households to seek out vaccination because their beliefs changed through high school, college, or media exposure. It can happen

Comment #5

It absolutely does, as "anti-vaxxers" are a rather self-contained closed culture that is informed by the same news channels, the same social media outlets etc.

Comment #6

Good catch on your part. As I'm sure you've seen, efforts to alter patients' traditional, familiar diets are usually condemned to failure unless you work within cultural norms and preferences. Giving up tortillas for some is like giving up rice or bread for others - pretty much unthinkable. More effective approaches involve reducing consumption and switching to healthier forms of familiar foods. The key is cultural awareness and humility. Community-based programs are often more successful because they adapt general dietary guidelines to the people they serve.

Comment #7

your essay about maskless, vaccine-skeptical patients definitely qualifies as a cultural encounter, so you ended up writing TWO assignments. Wish I could give you extra credit!

The main issue you focus on is a delicate one, given the politicization of the pandemic. Nevertheless, in my mind it is a false equivalency to say mask/no mask, it's a personal choice. Given the high transmissibility of this virus, the increasing frequency of mutations, masks are one of the few defenses we have. Vaccines alone are not soon going to halt the pandemic Therefore, it is

incumbent on physicians from a public health perspective to open a dialogue with maskless patients. Of course this must be done with respect and caring; and raising the issue is not the same as resolving the issue. Patients who come in unmasked will likely leave unmasked. But medical facilities increasingly specify that while on premises, patients must be masked, so it makes sense to have the conversation.

Comment #1

Great job of eliciting this nuanced understanding of her reluctance to take medication. It is easy to think the obstacle is always lack of information and understanding, but often the factors contributing to nonadherence are much more complex.

Comment #2

It sounds like you and your resident handled this situation superbly. Rather than blame the patient for her beliefs, you withheld judgment. Rather than split with the patient over different views of health and medical intervention, you emphasized being on the same team. You offered simple, easy to do, and culturally sensitive interventions. Lovely work.

Comment #3

Really great insights: 1) These are ongoing discussions, not one and done 2) the patient needs to feel safe in the clinical environment, and this isn't always easy when there are cultural and language differences.

Comment #4

you and the resident handled this situation beautifully, and your concluding thoughts are the perfect summary of how medicine should be practiced. As you say so eloquently, patients' backgrounds and expectations must ALWAYS be taken into consideration in developing a treatment plan; and the patient must always be engaged as a partner in this treatment plan. By listening to patients' stories and understanding how they understand a situation, you are more likely to find common ground and provide optimal care. Creating a context of caring and safety for the patient will maximize the likelihood of establishing a positive and trusting therapuetic relationship.

Comment #1

When you see this non uncommon pattern - worsening consequences of disease, persistent counseling by physician - it is a clue that you need to take a new approach. Motivational interviewing is one such tool to help break away from physician telling and patient resisting.

Comment #2

This is very interesting. In many cultures, men do not see it as their role to be responsible for their own health, rather relegating this responsibility to women (wives, mothers, daughters, sisters). It is often not so much "irresponsible" as it is a different understanding of what it means to be a man. Shifting this perception requires some investment of time in helping the patient build a new understanding of his role in his own healthcare. Sometimes family dynamics can be a factor - the patient may be "punishing" his wife and daughter, blaming them for his lack of improvement. Regardless of the reason, it's critically important to elicit the patient's thought process so that you can figure out an intervention tailored to the problem.

Comment #3

One thing that's touching about this story is seeing how Dr. Ashizawa does not abandon this patient, but continues trying new things to improve his adherence.

Comment #4

you were fortunate to see in real-time how an excellent physician is able to pivot, and change their style in response to facts on the ground. When you notice the same dysfunctional pattern repeating visit after visit, do something different! I think that, with all the patient's head nodding, Dr. A may also have sensed not agreement but despair. In response, Dr. A not only changed the content of his intervention (from warning of specific dangers of continued noncompliance to personal investment), but changed his style (from telling to asking). Both of these shifts showed an adaptability, a kind of improvisational quality, that is invaluable in clinical practice.

Medicine cannot be practiced solely by algorithms. It involves creativity and spontaneity as well. There are no perfect answers to such dilemmas. What is important is not to blame the patient ("patient doesn't care about their health"); and not to give up ("Why should I spend time with a patient who doesn't care?") Instead, make sure you understand as best you can the underlying reasons for the patient's behavior (maybe the patient is in denial of a scary disease; maybe the patient does not have the financial resources to live a healthy lifestyle; maybe the patient feels they "deserve" to be sick); and then craft an intervention (with the patient as full partner, as Dr. A did through his questioning approach) tailored to the concerns and needs of the patient.

Comment #1

It sounds as though you took a respectful, carefully calibrated to analyzing your patient's symptoms within the context of her cultural background and religious beliefs. I'm impressed that you researched some of these issues, just as you might research a medical condition to learn more.

Comment #2

this is an important conclusion. When you share a culture/background, often it helps you to "automatically" connect with a patient (sometimes assuming a shared background can also lead to difficulties, however); and such connection can be more difficult in the absence of such commonalities. However, as you discovered, it is possible to build those links by doing the work to better understand the other, just as you did.

Comment #3

this is an important conclusion. When you share a culture/background, often it helps you to "automatically" connect with a patient (sometimes assuming a shared background can also lead to difficulties, however); and such connection can be more difficult in the absence of such commonalities. However, as you discovered, it is possible to build those links by doing the work to better understand the other, just as you did.

Comment #1

Just having an interpreter available will not necessarily overcome communication barriers due to cultural assumptions and expectations.

Comment #2

Were you ever able to understand how he understood his problem, what he felt was the explanation for this problem, and what he thought should be done? This would take additional time, but it might offer a first step toward actually providing meaningful help to the patient.

Comment #3

This sounds like a very frustrating encounter. The patient apparently seemed to be seeking some sort of help; and you and your attending clearly wanted to help; but help did not necessarily occur. One of the things your essay illustrates is that overcoming language differences does not necessarily eliminate cultural differences. Time pressures makes such encounters particularly difficult.

Nevertheless, trying to elicit the patient's perspective on why he is there; how he understands his situation; and what he think can help him can sometimes establish a foundation on which to build. Sometimes a good interpreter can act as a "cultural broker" to shed some light on what's going on.

Physicians are always worried about throwing off their schedule; but on the other hand, visits that result in no real benefit for the patient have wasted everyone's time.

Comment #1

Great analogy, I love this! It presents a wonderful image that captures just why using translator services is so challenging. The basic structure of communication is altered.

Comment #2

And this is an excellent point as well. Because the time allotted for an interpreted interview is identical to a non-interrupted interview, the actual time spent assessing the patient's problems is cut in half.

Comment #3

I agree that the combination of multiple complex medical problems and the need for interpreter services is a very difficult one. You are right in saying that often the patient is shortchanged in the process.

Your insight about how translated communication becomes 4-way rather than 2-way is really interesting. It is literally like a game of telephone, and explains why so much can go wrong, even with a skilled interpreter.

Of course, there are no perfect answers. Having well-trained, committed, caring, and available phone interpreters helps, but does not solve everything. Sometimes it is helpful to "surface" the tensions in the room by acknowledging them, then reassuring the patient that you will do everything in your power to ensure that you have an accurate and complete understanding of the situation. Reducing the anxiety that inevitably permeates these situations can actually help in having a more satisfying interaction.

Comment #1

The patient and his wife are understandably frightened and upset. Although her accusatory statements are probably not doing much to facilitate the patient's care, from her perspective she is trying to advocate for her husband and ensure that nothing further goes wrong.

Comment #2

I agree. You had an outstanding role model in this chief resident - textbook perfect! Listening, not interrupting, taking concerns seriously, apologizing, explaining in understandable language and highlighting why a particular course of action was being proposed. You also did a superb job of observing and processing everything he did well, so that when you need to duplicate these skills, you will have them at your disposal.

Comment #3

Shannon, I believe you extracted exactly the right lessons from this example of medical error. It is natural to minimize and be defensive. However, this leaves the patient and family feeling not heard and dismissed. Your chief handled this so beautifully - listening, apologizing, explaining, all with a compassionate, caring demeanor - and the results were impressive. He defused the patient's and wife's anger so that this did not become a complicating factor in the care of the patient.

Comment #1

This is the key question. It sounds like both you and the attending tried to find an answer, but were not able to do so in this visit. I hope the attending will keep exploring in subsequent visits, so this important dynamic can be better understood and enlisted to further the healthcare of both husband and wife.

Comment #2

In general, of course, you want to avoid unnecessary testing as much as possible. On the other hand, if a test is inexpensive and poses very little risk, sometimes physicians will go along with the patient's request in order to build trust. The goal is to have doctor and patient sharing mutual respect and confidence and engaged in joint decision-making.

Comment #3

One of the more troubling aspects of the situation is that the husband did not seem to have responsibility for his own healthcare. It's hard to know how he felt about this. If he had voluntarily ceded healthcare decisionmaking to his wife, this might be one thing. If he felt intimidated by her, this would be another.

Comment #4

What a strange visit! The wife sounds very controlling. One thing you will discover in medicine is that physicians are not usually able to alter family dynamics (except of course in extreme cases, such as child abuse or domestic violence). Your best bet is to build on existing strengths. For example, praising the wife for her concern for her husband might help her relax and earn her trust. Also, we don't know the whole story. Often, in traditional relationships, the wife is responsible for the family's healthcare, especially the spouse's, and everyone has agreed to this caretaker role, including the husband. in Family, we have the luxury of proceeding slowly, taking time to figure out what is going on. It appears that the husband is in a helpless, passive role;and the wife is the dominating, controlling one. But getting more information might provide a deeper understanding that could be used to address issues like libido and vaccinations.

Comment #1

Interesting. So what are these tears about? Why is she crying all the time? What is the nature of her suffering? This might be a more important issue than the "reason for the visit."

Comment #2

This gets at the heart of the issue here. What IS the reason for the visit? The patient may have one idea (to get opiates? to get comfort?) and you, the medical student (as well as your attending), may have another. It's important to figure out how to get on the same page as the patient.

Comment #3

An excellent example that your emotions do not necessarily have to mirror those of the patients. Don't just react to the patient, respond the way you think will be the most beneficial.

Comment #4

It sounds like your attending handled this difficult encounter with great skill, modeling how to apologize, how to empathize, and also how to keep the encounter on track.

Comment #5

It's amazing how a skillful physician can transform a "difficult" patient into a satisfied one. It has to do with listening respectfully, supportive empathy, and the willingness to set boundaries compassionately and caringly.

Comment #6

Thanks for noticing this. Often in FM, learners feel overwhelmed by having to deal with family members as well as patients. It's true that sometimes family members complicate an encounter, but they can also play a very valuable role.

Comment #1

Truly listening to the patient - as opposed to just waiting till the patient is finished talking, so you can tell them what you want to do - is key in earning patient trust. Without trust, it is very difficult to care for the patient.

Comment #2

This was a great idea on you and the resident's part. The attending in this case could act as a cultural broker or mediator to make a decision that was sound in terms of our healthcare system but also honored the patient's wishes.

Comment #3

Yes. You and the residents listened carefully to her concerns, took them seriously (by discussing the barriers), and demonstrated that you were making an extra effort to resolve the problem. All these elements contributed to a happier, more satisfied patient.

Comment #4

What's so interesting about this case is that the patient felt happier at the end of the encounter, although it was not clear she would receive the medication she requested.

Of course, getting what you think will help you is very satisfying for patients. But so is simply being heard - respectfully and seriously. That is exactly what you and the residents did. The patient's reaction shows that you do not always need to "do what the patient wants" to cool down the emotions and build rapport.

Comment #1

So in a way, it was creating harm by misleading the patient into thinking she was adequately treating her disease.

Comment #2

The way your resident handled this difficult encounter seems excellent. 1) Start with where the patient is and respect that position. Arguing with the patient is rarely effective, and actually often results in their becoming more entrenched in their position. 2) Seek compromise - both/and approaches. In this case the patient's course of treatment is not actively harmful, but may not be doing much good. Validating her general disposition toward naturopathy while exploring other allopathic possibilities gives the patient the best possible chance for effective intervention. 3) Baby steps - "discussing options with an oncologist is less scary than facing a course of chemotherapy. Look for what the patient is willing to try.

Comment #3

as you discovered, a successful encounter rides on a nonjudgmental but creative approach. Telling patients to do or not to do something rarely works if they have an alternative perspective on the problem (if their life is actively in danger, of course you must make this effort). Although it can be frustrating and scary when the patient's life is at stake, letting the patient lead, respecting their views, emphasizing common ground, and continually seeking compromise and small concessions is the way to go. As your patient grows in trust for you, and believes you have her best interests at heart, she will be more likely to consider your recommendations. So be respectful but persistent. You both want the patient to be well. In these circumstances, you must work together to craft a way forward that the patient will accept.

Comment #1

Very well stated and I agree that the first loss in many cross-language/cultural encounters is the dr/pt relationship

Comment #2

Good empathy for the patient. It does help to remember that whatever you are experiencing, your patient is also feeling, even more intensely.

Comment #3

And here you have stumbled into post-COVID syndrome (not a real term, but from what I've heard widespread), where patients who have recovered still have all sorts of symptoms, real or imagined, feel ostracism from family and/or coworkers, and are terrified about recurrence of disease.

Comment #4

I hear your frustration, and acknowledge that it is very understandable. Perhaps another way of looking at this situation, however, is that the HTN (unless it was a hypertensive crisis) and the diabetes probably could wait till the next phone call. What you really did was honor the patient's needs and fears. You are correct that you did delay other people; and this is unfortunate. But unless someone was truly harmed by your decision, I think you may have given a great gift to this patient.

Comment #5

Ah, okay, I should have kept reading. You got there next sentence :-) Indeed, from that perspective, you might have saved the healthcare system a passel of money by keeping your patient out of the ER!

Comment #6

this is a thoughtful and interesting essay. In medicine, there is often not enough time to do everything you want to do for your patient. Part of this equation, as you point out, is that you are trying to meet the needs of MANY patients. That said, your priorities and those of the patient may not always align, and it is always worth asking yourself (except in emergent situations) whose priorities are more important. In this case, you gave the patient a great gift by listening to his fears and anxieties, and providing reassurance (and perhaps just a human voice). To do so through an interpreter was truly heroic! So my view is that your impulse was a good one.

Could there be refinements? Sure. Maybe, even with an interpreter, the interaction could have been a bit more concise. Maybe you could have gathered some basic information about the patient's hypertension and diabetes. But bottom line you honored the patient's agenda, and that is an important sensibility that you don't want to lose as your training progresses.

Comment #1

Yes, and it is always important to explore other possible reasons for patients not adhering to a medication, such as cost, or fear of side effects.

Comment #2

I respect your commitment to serving patients with a sense of cultural humility and an awareness of how structural inequities in healthcare and society at larger contribute to ill health. Like you, I have often witnessed situations where an interpreter is needed, but because of time constraints, physician burn-out or other factors, the physician simply muddles forward. Patients rarely have the courage to request an interpreter if none is provided. It is up to the physician to recognize that the few extra minutes it takes to use an interpreter are usually gained back in avoiding nonadherence and misunderstandings.

Comment #1

Interesting - I've run across this fear before in patients from various cultural backgrounds. The common denominator seems mistrust of the medical system.

Comment 2

The appropriateness of the patient's presence in this case probably depends, at least in part, on his age. If he were 8 or 9, he might not be able to grasp the arguments on both sides, and would likely be distressed by the disagreement between dad and doctor. If he was an older adolescent, even if he was uncomfortable, it might be valuable to participate in what, after all, was his care.

Comment #3

Yes, I think you're probably putting your finger on the problem. Especially in situations where the diagnosis has not been straightforward, it's easy for patients/parents to wonder, do these doctors know what they're doing? Why can't they figure out what's wrong? This history predisposes them toward skepticism, especially when they learn there is no "cure," and that treatment can be expensive, can involve surgeries, and likely will not completely solve the problem.

Comment #1

In such situations, both the patient and the family member have become your patient; and it is wise to acknowledge the family member's frustration. She is likely feeling guilty that she subjected her father to such a distressing night.

Comment #2

That ability to remain calm while all about you emotions are swirling is really helpful. Of note, being calm is not the same as not caring :-)

Comment #3

I agree with your assessment of the attending's handling of this situation. I do wonder if more could have been done at the front end to prepare the patient for what lay ahead. Many patients do not have a clear understanding of a hospital course. When they go to the hospital, they expect to feel better. They have no conception of all the invasive and unpleasant things that will be done to them. They do not expect to lose control over the bodies and their lives.

While we don't want to frighten patients, giving a better understanding of an important test that needs to be performed and how the patient will be prepared does help the patient feel less out of control when these things happen ("Oh, my doc told me about this"). Acknowledging that there will be some discomfort and even pain while emphasizing the value of the information to be obtained can be convincing.

It also sounds as though there was poor coordination in that the patient received the prep even though it was not clear he could receive the colonoscopy the following day. This type of less-than-optimal management can seem trivial from a healthcare perspective, but is deeply demoralizing and upsetting to patients. When it can't be avoided, it should at least be apologized for and empathized with.

Above all, as you insightfully note, the patient wants to feel cared about. The patient wants to feel the doctor is on the same side, not the opposite side. Sometimes, even conveying this caring and concern cannot dissuade a patient from fleeing the unpleasantness of a hospital stay, but it gives the best chance of success.

Comment #1

What do you think the patient was struggling with here? Why did he share this with you?

Comment #2

So how is motivational interviewing different than giving the patient information about how diabetes will affect him physically?

Comment #3

This is a very understandable feeling. You want what's best for the patient, and you want him to want that too. I think he probably does (that's why he's at the doctor's) but he's scared of what lies ahead; and he's scared about what it will take to improve his health.

Comment #4

I think the issue may be that information alone often isn't sufficient to overcome patients' fears, skepticism, and uncertainty. Your job is to look for a way in with the patient to understand their resistance, and then jointly problem-solve how to dissolve it. On this journey, the patient will be an active participant in their own health. Motivational interviewing can be very useful in finding these keys into the patient's subjective concerns.

Comment #5

Motivation and readiness to change are often a process. And yes, the patient is listening and considering your points, even if he is not (yet) agreeing. Patience is a very important part of any physician's skill set, but especially so in primary care. Here, the luxury of continuity of care gives the physician the opportunity to convince the patient over time about the best way forward.

Comment #6

as you know, patients often feel ambivalent about their healthcare. On the one hand, they want to be healthy. On the other hand, they are resistant to the image of accepting themselves as sick, especially with a chronic disease for which there is no cure. They are likely frightened about the implications of treatment. Following physician recommendations also means admitting that they are sick, even when they still feel good. And there may be other layers as well, such as a needle phobia, which can be overcome with proper training, but is a very real deterrent. So the physician's job is to figure out where the barriers are, and how to overcome them. As you suggest, motivational interviewing can be helpful in this process.

You also make an excellent point that change often does not occur in a single clinical encounter. By continuing to work with a patient, building trust, providing information, nonjudgmentally exploring resistance, the physician over time can shift patients' views. Motivation is a process, and something that the dedicated physician can help build.

Comment #1

I wonder what "professionalism" looks like in these circumstances. I assume it means you did not yell or berate the father, as you might have wanted to. What were your interactions like? Did you ever revisit his beliefs or did this seem futile?

Comment #2

I agree with you that there is a place for outrage in medicine, and this is one of them. The abuse and neglect of children who are dependent on their parents for love and support is a shocking thing. The interesting thing, in my view, is that what do you do with this outrage. This father deserves judgment, but are you his judge? Perhaps, in the sense that you are an advocate for his child, and will recommend investigation by CPS. So here outrage may be channeled into advocacy, which is a good use of this emotion. It is always a challenge to behave "professionally" in the face of egregious wrongdoing that harms an innocent child, so I'd be interested in learning more about what this means to you.

I always wonder when confronted with such extreme and apparently crazy beliefs, where did they come from? This is a worthwhile question because it can help you determine the likelihood that they can be changed. I also start thinking about whether there are underlying psychiatric conditions that could be contributing to the person's views. Unfortunately, a lot of legally sane people hold really bizarre ideas. As you know, abuse tends to be intergenerational, so this abusing father may himself have been the product of an abusive environment. None of this in any way excuses his actions toward his child, but they do help point the way toward determining whether he can ever function as a responsible parent.

In this case, I'm glad that your very justifiable anger translated into protection of and empathic care for this vulnerable baby.

Comment #1

Good observation, probably not worth addressing immediately, but worth registering, in case these emotions become evident as the interview progresses

Comment #2

What do you think was behind this response? In other words, what made him react so strongly

Comment #3

Yes, hindsight is always 20/20, but we can learn from it. I think you realize that those questions, although well-intended, did not address the patient's underlying concerns. What do you think might have been a more effective action at this point?

Comment #4

This is very honest on your part, and I appreciate your transparency. Yup, we all mess up sometimes. Sometimes no matter our commitment, we are simply not able to do our best. It helps to acknowledge it, so that you can be better prepared next time to deal with time management, sleep deprivation etc. Patients expect doctors (and medical students) to be prepared to see them. This is fair, part of the therapeutic contract. When it is literally not possible, honesty is the best policy. Giving the patient a head's up that as a result of difficult circumstances, you haven't reviewed their chart thoroughly, and would like their help in being brought up to speed. As you learned, better still is to read the chart :-) This is your commitment to your patients.

Comment #5

I disagree a bit with you here. I think there might have been some comfort you could have provided, but probably not by asking what time his next appointment was. Patients with serious chronic diseases, such as cancer, are especially anxious that any symptom is a sign of cancer recurrence or metastasis. Often what they need is reassurance that their doctor understands the context of their symptoms, is aware of the possibility of cancer manifestations, and will think carefully about what's going on.

Comment #6

I agree that, as we have seen time and again during the pandemic, a hallmark of good doctors is their flexibility and adaptiveness to unexpected and challenging conditions. I'd add that resilience is also about recognizing when we've stumbled, learning from it, and going forward, exactly as you've done.

Comment #7

thank you for such a transparent essay. I'm very impressed. This was an unfortunate encounter - an anxious patient with a history of cancer and bone mets meets a student who hasn't studied his chart. Mistrust and distress ensue. Learning from our fumbles is always painful, which is why far too many people avoid it. You, by contrast, dissected the situation with clear eyes, and realized that being as prepared as possible (and the precise meaning of this phrase will indeed differ based on circumstances) is part of your commitment to your patients. If this patient was a return patient with diabetes, you might have been able to get away with not having precharted, and then you would have learned nothing except that when you "didn't have time" you didn't need to review the chart. So, although painful, this experience was also invaluable.

I also wanted to address what might have been going on with the patient. As noted, patients with cancer are understandably terrified that their disease is progressing. If you had known that, you could have prepared yourself for the patient being worried about seeing a med student, and needing you to convey special concern, attentiveness and caring. The more context we have when we interact with patients, the more likely we can truly meet their needs, both physical and emotional.

Again, you did a wonderful job of processing this encounter with humility and clear-sightedness. You extracted an important lesson, which doesn't always happen. Hold this lesson close, and thank the patient who gave it to you.

Comment #1

this is a passionate and important essay. You make some excellent points about the intersectionality of ethnicity/race, socioeconomic status and gender identity. I hear what you're saying that pronouns may be low on the priority list for someone who routinely encounters bias and discrimination, who is homeless, depressed, and with a history of substance abuse. And certainly paying attention to patient preference (or lack of interest in) pronoun use is no cause for self-congratulation, but merely a fundamental human courtesy. And there should be no question that all of us are implicated in the inequities of privilege and power that increasingly dominate this country. I agree it is incumbent on us to use whatever influence and levers we have to ally with those in the fight for a more just society, so that people in Mr. F's situation can benefit from real support and resources to build a more secure, safer, and happier life.

That said, in my view it is important not to trivialize or dismiss language, which is also a powerful weapon to further disenfranchise and demean those who are already powerless. People of color, people who are unsheltered, people who struggle with addiction and/or mental disorder also deserve to be named who they are and referred to in ways that are congruent with their lived identity. Pronouns may not matter to some; they may matter a great deal to others. While language cannot put a roof over someone's head or bread on their table, it can help to make them whole in their own eyes. Language can be a way of acknowledging humanity and restoring a measure of power. So my view is that it is both/and. Mr. F should have a roof over his head, security from being beaten up by thugs, treatment for addiction if needed, help with depression, and use of the name and pronouns

that are consonant with how he views himself. It may take weeks or months or years to secure housing and this goal should be pursued diligently. But language can be changed in a moment and sometimes can make a big difference as well.

Comment #1

That's great you were thinking about what all this "doctor-shopping" might mean. Is he unhappy with his care? Does he feel these other doctors did not listen to him? Did he lose his healthcare coverage? That is certainly a red flag worth pursuing.

Comment #2

I love this involving awareness! How interesting that both you and the patient, albeit for different reasons, were experiencing the same emotion - frustration! Shifting your attention from self to patient was a terrific exercise in empathy, and not easy for any of us to do when we are feeling overwhelmed and upset.

Comment #3

I would count this a success! You accomplished something invaluable in clinical practice - conveying concern and care for the patient, as well as offering concrete help where you could. This experience will increase the likelihood of his returning to clinic and seeking additional care for his remaining problem.s

Comment #4

In this insightful example, you see how the patient's frustration with care may contribute to his doctor-shopping and poor compliance. Since you were feeling a similar emotion, this insight is also a good reminder how an emotion such as frustration can trigger unskillful responses, and in a sense is a "warning" not to have your own (quite understandable) frustration drive the encounter. Instead, by first recognizing your frustration, and then recognizing that of the patient, you were able to find empathy in a difficult situation. This in turn forms the basis of a genuinely therapeutic relationship, without which providing quality care is impossible.

The outcome for this visit was truly excellent in my view. True, you did not solve all his problems (how could you, with a list that long!), but you achieved the most important thing: at the end of the encounter, the patient felt seen and heard. He trusted his providers and hopefully will return to them to address his other problems. When the patient feels the doctor actually cares about them, they are

more likely to follow through with appointments and more likely to adhere to the prescribed treatment plan.

Comment #1

I have heard this many times from both patients and medical students. Yet another argument in favor of a diverse physician workforce, as if one were needed!

Comment #2

Receiving the patient's story is indeed a privilege, and it's wonderful a) that you recognize it as such and b) that your patients feel safe enough with you to entrust you with their stories.

Comment #3

Very empathic, and an important awareness in caring for this patient that she is experiencing a very serious illness far from home.

Comment #4

Yes. While of course we don't want to generalize about another culture based on our own, we can also get hints about how another culture might view a situation by considering our own. Many different cultures are organized in some way around family, and knowing this can help you connect with the patient in positive ways.

Comment #5

it was lovely to hear about the ways you are able to form a relationship with your Latinex and Spanish-speaking patients through a shared language and often a shared culture. It is difficult to be sick and frightened and then be struggling with language and/or cultural differences.

Second, I really liked the way you approached a patient from a different cultural background than your own. You listened carefully to her story and were full of empathy for her plight. You also realized that while your cultural backgrounds were quite different, they might share a common emphasis on the importance of family, especially in taking care of those who are sick. This made you especially sensitive to her isolation while having to deal with a very serious medical situation. A good family medicine approach would consider this aspect of the patient's care, and attempt to bolster her support system.

Comment #1

You know, I think no one really knows how to respond to such sharing. Perhaps what is most important is not the words you choose but the fact that you are THERE, witnessing her suffering; and that you did not turn away.

Comment #2

Very sadly, this sounds like the most truthful position. Honesty, coupled with lots of compassion, is essential in such situations.

Comment #3

Laying it out like this sounds like a simple, step-by-step process, which is very much is NOT. Seeing what needs to happen and then figuring out how to help the patient get there are two very different things. As above, honesty is essential, but so is compassion for the patient's struggle.

Comment #4

Of course, palliative care is not the same as "giving up" although this is what it signifies to many patients. From what you describe, it sounded as though Ms. Rhea was nearing the end of her life. If by chance she was able to be discharged, she might want to spend her remaining time in relative comfort so that she could say goodbye to her son and dog.

Comment #5

It is worth considering that there are many kinds of hope - hope for cure and recovery, hope to be free of pain, hope to have time to say goodbye, hope not to be abandoned by one's care providers. One of the arts of medicine is helping see what kind of hope matches their situation.

Comment #6

This emotional response is an interesting one. I've noticed it often in teams - it is almost as though they are angry with the patient for not "getting it." Once the team makes its best determination of the situation, there is often the feeling that everyone else should neatly fall into line. But human beings are not like that. The patient was working on her own timetable, processing her own incredible impending loss, of life, of love. She was distraught at what would happen to her son and dog. The team can evaluate the prognosis medically, but they cannot expect the patient to act like a doctor. She is a mom and a dog parent, and their job is to honor these roles even as they help her see the likely outcome of her disease.

Comment #7

thank you for such a thoughtful and honest essay. You are wrestling with questions that have no clear right answers. I really respect that you are asking them - too many physicians have stopped asking them, or never started.

Research on patients facing end of life issues suggests that patients want compassionate honesty - that is, they want a doctor who will tell them the truth, but in a warm, caring, and compassionate manner, a doctor who understands and empathizes with just how overwhelming and devastating this news is.

I was intrigued by your comment regarding the team's "frustration." It's important to remember that there are at least two tasks that need to be accomplished - 1) the medical determination of prognosis and 2) the patient's coming to terms with this prognosis. Both can be complicated, but often the second is the harder one. This is where frustration needs to give way to patience, listening, compassion, and a kind of agape love for this person nearing the end of her life. I think if the team had done more listening to the patient about her son and dog, as you did, they would have allowed themselves to understand the situation from her perspective - and from that starting point, they could have taken steps (perhaps by involving social work or the chaplain) to support both patient and her sister (who was likely also feeling overwhelmed and despairing) in facing what lay ahead.

When the patient's concerns (son and dog) are honored, rather than prioritizing the medical agenda (bring in the palliative team), paradoxically the patient usually moves more quickly toward an acceptance of a very painful reality. By listening to and acknowledging their distress, you can help them be present in whatever remains of their life.

Comment #1

I admire this decision, and feel it is very important to be a trustworthy ally helping patients to develop their own advocacy skills for themselves, their families, and their communities.

Comment #2

Great nonjudgmental question to begin a conversation about health. I suspect many physicians have never taken the time to open this door; yet it can lead to some place immensely valuable.

Comment #3

Thank you for this positive narrative, which beautifully illustrates the connection between high health literacy and empowerment regarding personal healthcare.

You also make the important point that health literacy varies from individual to individual and from community to community. I was especially interested in your observations about many Latino patients. I wonder what you see as the explanation of the relatively pervasive low health literacy. From my own work at FHC-SA, it seems to be a function of language difference (inadequate doctor-patient communication), cultural difference (i.e., different expectations regarding the roles of doctors and patients), and low socioeconomic status (which prioritizes more immediate concerns such as work, shelter, and food over health).

I also strongly support your commitment to patient advocacy. Health literacy is obviously not an innate trait. An "activist" physician can do a lot to help patients revise their attitudes toward illness and learn to take a more active role in both their own and their families' and communities' health

---

Comment #1

Good questions. I have also seen this pattern with older male patients and their wives, so there may be generational issues involved as well.

Comment #2

I agree with your analysis. In most similar situations I've observed, it seems that the husband has gladly given over responsibility to the wife for his healthcare.

Comment #3

This is a great reflection on your part. I've noticed this pattern as well, but no student has ever written about it. I suspect factors of culture, family, personality, and age all contribute. In the situations I've seen, this dynamic allows the man to preserve a certain macho indifference to his health; while it allows the wife to show attention and caring through her leading the conversation. Of course, as you imply, if anything interferes with this dynamic (e.g., the wife cannot attend a medical visit, or the wife herself becomes ill) it may make it more difficult to provide quality care to your

patient. It is also a rather uncomfortable situation when the patient does not take responsibility for his own health. So it raises questions about whether you should accept the dynamic, or try to adjust it so that the patient is willing to become more engaged. Such questions do not have simple answers. Intervening in a family's usual way of doing things is fraught with potential problems, and must be approached both humbly and respectfully.

Comment #1

It sounds as though you and the attending made a valiant effort to help this patient understand the value of vaccination. I've learned that with anti-vaxxers, some are unshakeable, no matter how much concern is expressed or fact-based information provided. This patient may have belonged in this category.

Comment #2

Good for you. It is always worth considering if there isn't a way in through the patient's barriers. I respect that you took the time to look for other approaches.

Comment #3

And then you could follow up with an empathic comment, so the patient knows you understand the feelings behind the facts. "That must have been very scary to think that. No wonder you're reluctant to consider getting a vaccine." You could ask about other vaccines she might have received as a young child, and whether they'd had a negative effect on her. You might establish whether she had ambivalent feelings about vaccines, or whether she was absolutely opposed to them under all circumstances. It is also true that some colleges require some vaccines (although HPV) and you might ask her her thoughts about that. What's important in any such conversations is that they are conducted in a nonjudgmental manner, not designed to show her the illogic of her arguments or to "catch" her in inconsistencies.

Comment #3

I liked best about this essay is your persistence with this patient. You employed different approaches and arguments in an effort to shift her thinking.

And even after the encounter was over, you continued to think about ways you might have persuaded her.

People who are anti-vaxxers can be very entrenched in their beliefs, and they often live in hermetically sealed worlds in terms of the information they consume. What's interesting about this patient is that she is not reflecting the views of her parents, but seems to be able to persuade them to support her beliefs. This suggests she holds her convictions very strongly. Nevertheless, she is quite young, and perhaps exposure to other viewpoints in college as well as a caring physician can help her reevaluate her position.

These conversations can be very frustrating, but it is important to keep them "conversations" - nonjudgmental, listening, empathic. It can take patients with these beliefs a long time to trust mainstream medicine, so even the fact that she is in clinic is a hopeful sign. If she was able to continue regular care, it might be possible to build on this beginning

---

Comment #1

Great question, one often omitted in the process of "educating" patients. The patient may understand the need to eat more fruits and vegetables, but if she has no ability to access such foods, then this "education" is meaningless.

Comment #2

I have often heard from other students whose parents are immigrants and who grew up in a specific cultural community that, although the specific background is different, having this experience helps them be more aware of the issues and concerns facing our FQHC population. Your interaction with this patient demonstrates that point, particularly in the way you translated generic dietary recommendations into concrete recommendations that respected the patient's cultural background as well as the challenges of living in an underresourced environment.

I particularly liked your point that how we respond to situations depends a lot on how we frame them. If we think of something as a barrier or an inconvenience, we will tend to resent it, ignore it, or try to get past it as quickly as possible. If on the other hand we are curious about the difference, and wonder how it can help us learn to take better care of the patient, it can become another pathway into a deeper connection.

Comment #1

Thanks for getting in your assignment. It's a fine line, isn't it? There's the perception of the mother - more testing should have been done, the neurologists were not very responsive - and the perception of the medical team - the approach taken earlier was reasonable and appropriate. Although you and your team did nothing wrong and were not culpable, you now have to find the fine line of supporting the mother and earning her trust while not throwing the previous team under the bus.

It is understandable under the circumstances that this mother would feel frightened and stressed in the face of her son's worrisome and initially unexplained symptoms. As a result, communication is even more important than it normally is, and to me this is the key takeaway lesson. You cannot always provide answers as a physician, but you can ALWAYS ensure that the patient/family do not feel ignored or abandoned. Sometimes, when doctors do not have answers, they tend to avoid these patients or shorten their interactions because they feel inadequate and guilty that they have somehow let the patient/family down. This behavior can be interpreted by patients and families as a sign the physician doesn't care and is not invested in the case. As you realize, keeping the patient/family apprised of the team's thinking and actions is critically important and can make the difference between a mistrustful, fractured relationship and parents and medical team working together.