Comment #1

Thoughtful analysis. In addition to the excellent points you raise, there can be emotional factors involved (anxiety/fear/frustration) that lead to denial or non-adherence in the patient; and lack of patient-centeredness in the physician. Of course cultural and structural factors can also complicate these interactions.

Comment #2

Good point. I often hear patients say "I was never told that" while their doctors insist "I explained it all to them." It's not that either party is wrong, it's just that the communication process was inadequate.

Comment #3

Excellent assessment of the emotions (in this case anxiety) driving the patient's behavior.

Comment #4

Sometimes it is the case that until their concerns are heard and addressed, the patient is unable to "hear" the physician's agenda.

Comment #1

Yes, we've seen this in patients from other countries and also in rural areas of the US

Comment #2

I'm glad to see that, while discouraging, this reality motivates you to work to providing more equitable, accessible in this country and around the world.

Comment #3

there are many factors not of the individual physician's making that can lead to disillusionment and cynicism. We can apply individual band-aids, which help, but as you note, addressing systemic injustice and building fairer healthcare systems here and elsewhere is the only real answer. Although understandable, despair is never the answer; action, even small action, ultimately is.

Comment #1

As you know, there is still a lot of stigma associated with mental illness in many communities, which makes treatment more challenging

Comment #2

I'm glad to see you did not allow yourself to become frustrated with this patient. Acceptance of a potentially stigmatizing condition (in one's own eyes, as well as in the eyes of the community) is a process. In addition, the patient had concerns that her mental status would be used to take away her son, to whom she sounds devoted. Therefore, you and your attending embarked on exactly the right strategy: first and foremost, assessment of suicidality; then situation this patient in the context of her lived life; finally providing reassurance and offering resources. She might not agree right away, but to me, the very fact that she disclosed her worries shows she was beginning to trust you.

One further thought is that you might be able to activate her engagement with treatment by linking it to her dedication to her son. Untreated depression can be disabling; and your patient is already complaining of fatigue. Treating her mood disorder might actually make her a more energetic caretaker for her son. So while she may be afraid of acknowledging her depression, she might consider tackling it if it meant she could better care for her child.

Something else that Dr. Vega might have mentioned is to consider using terms, especially initially, that are not so upsetting. While you don't want to deceive the patient about her diagnosis, explaining that depression just means a condition that involves both physical symptoms (poor sleep, weight gain, weight loss, fatigue etc.) and emotional symptoms (significant sadness, tearfulness, hopelessness, irritability, anger, anxiety, feelings of worthlessness or guilt etc) might help her understand the diagnosis as an illness, rather than a weakness or "being crazy." Focusing on symptoms (how's your mood today? Are you sleeping better?) may feel less pathologizing to your patient.

Comment #1

Caring for patients across language and culture does present many challenges, yet with creativity and attention it is still usually possible to provide optimal patient care.

Comment #2

There is no question that the first victim of interpreted communication is empathy. Here again, however, by emphasizing tone of voice and other nonverbal cues, patients can feel somewhat reassured that you have a personal commitment to their wellbeing.

Comment #3

What a lovely observation - culture certainly changes from generation to generation, but one hopes that traditions in some form can be perpetuated through the meaning that individuals, families, and communities find in them.

Comment #4

you have a deep understanding already of what lies at the heart of medicine - a caring and respect for patients' and families' stories.

Comment #5

Since it is impossible to become expert or even knowledgeable about the multitude of cultures on our planet, a more realistic and more appropriate strategy is one of cultural humility. Of course, it behooves any good physician to learn as much as possible about the customs of mores of the communities in which they practice; but overall, learning from your patients is the most fulfilling and satisfying way of understanding another's culture.

Comment #1

Yes, this is the deeper insight, the sense of vulnerability that patients experience when they can't hear, understand the language OR the system. Your insight is what we must always keep in mind.

Comment #2

This is a very empathic statement and I love that, as a (future) physician, you are interested in thinking about your patients' lives beyond what you see in clinic.

Comment #3

Your empathy for this patient was palpable. If you were his actual continuity physician, this might be an aspect of his life that you would want to understand better. How did he cope with being "more or less on his own"? How did he navigate "a very isolating world?" Knowing the answers to these questions would help you know your patient, his strengths and resources, which in turn would better equip you to develop meaningful treatment plans for his various medical problems.

Comment #1

A very empathetic comment. Our healthcare system is fragmented and complicated, and especially so for someone from another country. As you well know, medicine is based on trust and faith in the competence, skill, and caring of healthcare providers, and it is the responsibility of health professionals to ensure they honor that trust.

Comment #2

Awesome thoughtfulness. This is what has been called compassion-in-action, where the physician goes those extra steps to ensure that the comfort and wellbeing of the patient are considered as much as possible.

Comment #3

Another very thoughtful gesture. Such gestures are important in and of themselves (in this case, so the hospital staff is not scrambling last-minute to find their patient food she can eat), but also are highly symbolic messages to the patient that their doctor is thinking proactively about them.

Comment #4

This is an excellent point - when the patient is anxious, on guard, and uncomfortable, she has less available energy for the health tasks before her.

Comment #5

All excellent conclusions. Thinking outside the box is often necessary to find solutions to the systemic shortcomings that affect too many patients. Demanding a high level of care for all patients, regardless of race, gender, class, or immigration status is another given that it is sometimes all too easy to lose sight of; and engaging actively with patient needs arising from their culture and belief system also ensures the happiest, most relaxed and trusting patient possible.

Comment #1

Oh my. So the casual racism implicit in referring to her first doctor as "Asian" is borne out by this request.

Comment #2

I like that, professionally and respectfully, your resident set a limit and advised the patient what was and was not acceptable in this healthcare system.

Comment #3

The first words out of a biased mouth are often 'I'm not racist.' The patient clearly has certain biases that the healthcare system should not be supporting.

Comment #4

I imagine this was indeed quite painful. These kinds of micro (macro?) aggressions should not be "brushed off," as they can cause emotional and psychic damage.

Comment #5

I wonder if this is the only option. I have complete respect for your desire not to let your feelings compromise your patient's care in any way. However, your feelings as a medical student and future physician also matter. I wonder what would have happened if you had shared the patient's comments with your attending. Hopefully, they would have addressed the situation on your behalf. It would also have been interesting to see how the patient would have responded if you'd disclosed calmly and factually, "You know, actually I identify as Asian American. I liked taking care of you today and hope I'd be able to take care of you in the future." You can push these encounters a little further by bringing an attitude of discerning curiosity to the interaction.

Comment #6

In the end, of course it should be up to you how to handle such uncomfortable situations. I am only suggesting that there might be more than one way that is professional and that honors your feelings while not rupturing your relationship with the patient.

Comment #7

There are some very good articles on this point, written by physicians of color, who point out that they do not feel obligated to embrace "educating" their patients about racist attitudes; nor do they feel that they should have to "defend" their legitimacy ("Actually I went to Harvard and have an MPH from Stanford" etc.).

Comment #8

Your feelings of discomfort are of course completely understandable. Your desire not to break trust with your patient is also admirable. I was especially touched that you made every effort not to allow your feelings of hurt or insult to affect the quality of care the patient received.

That said, it is possible that there may be more than one way to respond in such situations. Setting a limit on the patient's racist desires seems appropriate to me. Surprising the patient's assumptions ("I'm Asian American") might also be a way to push back. At the least, my view is that it is important

not to carry the burden of micro (macro?) aggressions alone. If you are not comfortable confronting your patient (and this might not always be the best strategy), talk to your attending or to other team members, who will support you.

In encountering similar situations, one thing I've heard again and again is that what often hurts the most is when other team members are silent in the face of the patient's racist behavior. This silence is almost never from agreement, but from awkwardness, from not wanting to alienate the patient. But it leaves the "target" feeling very isolated and alone. So even when it is hard to speak up on one's own behalf, it is important to support colleagues, fellow students, and even superiors.

I remember one encounter I witnessed where the patient (a Vietnam vet at the VA) said he did not want to be treated by his female, Vietnamese physician. A resident stepped up and said politely and calmly, "You know, Dr. X is one of the best physicians on staff here. You are so lucky to have her as your doctor." The patient agreed (with some ill-grace it should be noted) but later Dr. X confided how much it meant that someone spoke for her.

Comment #1

You know, sometimes you have to address the elephant in the room. Talking to the patient about monitoring her blood sugars more closely or trying a new medication is likely not going to work because of the patient's despair. Unless she can find a reason to hope, she's already checked out.

Comment #2

And this is key - the attending pivots beyond the "diabetes conversation" to looking at the patient in the context of her life. The doctor listens to her story. Yes, this takes a little extra time, but also leads to the realization that the patient may be not just discouraged but depressed.

Comment #3

It illustrates the importance of listening to the patient's story rather than just treating their disease. You and the attending heard and saw your patient's despair. You also realized that discussion of lab trends, new medications, blood glucose results was going nowhere. Fortunately, you had a skillful attending who decided to try a different tack and talk about the patient's life instead, which revealed many other issues contributing to her depressed mood. I hope the patient was able to follow through with her baby steps forward; but even the fact that she was willing to "try again" represents a big step in my book.

Comment #1

So sad. This highlights the limits of our technological supports. I wish you'd been able to have an in-person interpreter with you.

Comment #2

This is a great insight. The way our medicine, itself a product of our culture, "understands" symptoms, diagnosis and treatment does not necessarily make sense to others coming from different backgrounds, sometimes even within this country. How to remain open to these different assumptions, understandings and expectations is not a simple affair but being able to acknowledge these differences is an important step in trying to bridge them.

Comment #3

I really like this. You are starting with the patient's experience of their illness, which is what matters most to them - usually a lot more than a specific diagnosis or even an explanation based in a language (not necessarily English but medicalese) that is not particularly meaningful to them.

Comment #4

I really appreciated your essay. It shows a lot of personal awareness as well as insight into the gaps that often separate doctors and patients particularly in an increasingly diverse world. A physician colleague once told me that you should approach every doctor-patient interaction as a cross-cultural encounter, no matter how apparently "similar" or "different" the patient seemed. I think this is very good advice. It reduces assumptions and helps us challenge our own biases.

I also admired your realization that the best place to start an interview is always where the patient is, not where the doctor is. As the interview progresses, you will build bridges, but this patient-centered approach communicates that you respect your patient's reality and want to honor it in the way you care for them. This builds trust and helps the patient feel safe, which will make eventual treatment easier.

Comment #1

I admire this humility. We can never fully understand another person, and to say we do is presumptuous. But it is possible, through respectful listening and empathic imagination, to move a little closer even to people whose life experiences are very different from our own.

Comment #2

If you can deepen these two skills, you are already well on your way to understanding the "art" of medicine.

Comment #1

you identify the dilemma well from the student perspective, and I have heard similar thoughts from many students. Of course you would prefer that nothing interfere with your education, which is critical to making you a good doctor in the future. On the other hand, patient care of course is the overriding priority. In this case, you understand very well the reasons for the patient's refusal to see a male physician/medical student; they are rooted in . Where it gets tricky is in situations where the reasons for the refusal make less sense - i.e., I don't want to be seen by a student; or even reasons related to race/ethnicity/religion/gender. In most cases, healthcare providers attempt to honor patient requests, although I have seen examples of pushback, especially from colleagues, when it involves race or gender ("You're making a mistake not to want to see Dr. Nguyen. She's an outstanding doctor").

While today, most healthcare systems are very attuned to the preferences of female Muslim patients, 20 years ago it was a different story, and there was a lot of eye-rolling and exasperation at what were perceived to be unreasonable requests. It's interesting to consider that our standards of what is reasonable and unreasonable in terms of patient requests changes with time and education. Still, when patient requests that are not honored it is most likely because they cannot be easily accommodated (i.e., no other physician is available).

Comment #1

This is an interesting observation. It suggests to me that you felt Annie did not trust you - or maybe that you did not trust

Comment #2

I'm glad you were not completely discouraged by this encounter, Brian. It is easy to dismiss a patient like Annie as uncooperative or nonadherent or simply incorrigible. But especially in a continuity care situation, a more fruitful attitude is one of curiosity - will it be possible to overcome her ambivalence (wanting/not wanting help)? The more this becomes an interesting puzzle and less a personal affront, the easier it will be to hang in

Comment #4

I can well understand your frustration with this patient and your perception that this was a wasted visit. Perhaps but perhaps not. If we expected certain specific goals to be achieved which were not (and this is how the healthcare system is set up), then I agree. But if we think of this visit as the opening move of a dance, then perhaps it has some value. After all, you learned important things about Annie - she's in a lot of pain, so much so that she's sought ED help. She also is very afraid of interventions that might help her - why? Perhaps she's afraid of being even worse off, a common fear of chronic pain patients. Maybe she just needs to build trust (as you suggest) in her doctor, before she accepts their guidance. She may just need someone who listens with caring and respect and understands it's no picnic growing old and being in pain.

I found your concluding sentence to be quite moving. Your commitment to "try again to connect" says it all. Sometimes patients are "testing" you to see if you can deal with their aggravating behavior. If you simply persist, they start to relax and feel like you're on their side. It's possible this might happen.

Comment #1

You do an excellent job of contrasting some of the difficulties that can arise in family-based healthcare within the context of a very individualistic, self-sufficient culture like (very broadly speaking) the US with the strengths of a culture with greater respect and valuing of its older members.

Comment #2

you are absolutely right to pay attention to patients' families. Families usually have a significant effect in how a patient will be cared for. As you describe with such insight, assumptions about independence and interdependence within families and societies can significantly impact family members' involvement with a patient's care. You are correct that in this country, often elder care is perceived as a burden, although a large percentage of care for the elderly and infirm is in the form of

unpaid usually family labor. What we need to remember is that, while there are always individual differences, our perceptions are also significantly shaped by our culture and environment. We do not live in a society that supports care of its elders, so in a way individuals just reflect the values and priorities of the larger society. You did an outstanding job of highlighting the contrasts and implicitly suggesting that we could learn a lot about respect for elders from other cultures.

Comment #1

Yes indeed. Having talked with several JW patients over the years, I've seen a range of attitudes from calm acceptance to great anxiety. I also understand that there is some flexibility, at least for some adherents, about what constitutes a blood project. It is a very difficult situation for precisely the reason you identify - that it would easily be possible to save these patients.

Comment #2

Absolutely the right approach, and I think the usual ones these days (earlier, there were definitely attempts to "argue" patients out of their beliefs which were almost uniformly unsuccessful, and when they did succeed, often had awful consequences including ostracism from the community and the patient feeling they would be consigned to hell.

Comment #3

Perceptive observation, although with adult patients there are many examples of them making choices that go against their own welfare (which is not quite the same as non-maleficence, but does prioritize autonomy above patient wellbeing).

Comment #1

It's great you learned this, as it lets you know your patient favors home remedies and other alternative approaches.

Comment #2

This is such a sad commentary on our healthcare system, but it's great that you were able to form the kind of connection with this patient that made her feel safe enough to disclose her dissatisfaction with previous providers.

Comment #3

Excellent, so what you are doing here is recognizing explicitly that you and your patient are starting from very different perspectives. By surfacing this difference, you make it more likely that it will not unconsciously affect your interactions with your patients (i.e., you might judge her for "unscientific" beliefs)

Comment #4

And here you are looking for common ground in the fact that, for both of you, community is important, although it is achieved in different ways. By viewing your patient's faith through this lens, you make it less alien, more familiar to yourself, and as such, something that you will have less judgment about.

Comment #1

I realize that it might have been advisable to perform the pap smear and exam, but I feel uncomfortable even just reading this account. I wonder if the patient could have been better prepared for the exam; and even how necessary the exam was at this time.

Comment #2

These are all excellent questions. I think by getting to know the patient a little better, you might be better able to tailor consent to her intellectual level; and interpret the cues she gives regarding her distress.

Comment #1

as you note, this is a very complicated situation. What I appreciate is that you recognize the structural, family, and psychological factors contributing to her difficulty in establishing trust. This information further "complicates" the encounter, but it also gives you insight into understanding and perhaps overcoming her mistrust.

Comment #2

This is an honest acknowledgment. All the workshops and trainings in the world can't really prepare you for the nuances of a real-life clinical encounter. The more you can stay present and centered, the better chance you have of using the skills you've learned (and they will help, although there are no guarantees).

Comment #3

I wonder if you were able to talk with her about this belief. What made her think this? Could medications ever be her friend? This might be the key point to explore and hopefully shift.

Comment #4

Maybe there is a third alternative? It is not paternalistic in my view to correct misinformation (or disinformation) and provide accurate facts. You cannot force a patient to take medication (unless they are declared incompetent to make their own decisions, which is not the case here). And of course you do not want to "stand idly by" - this is not why you became a doctor. So what is left is the hard work of being a physician - engaging with kindness and firmness to win her trust; look for ways of disabusing her of her misconceptions and fears; and above all try to stay engaged even if you can't resolve the disagreement. Warn her about the possible consequences of not resuming her meds, but in a way that shows caring and concern not patient blame.

Comment #5

Absolutely agree. This is a superb plan. The biggest problem this patient has - worse than all her very serious diagnoses - is her lack of trust in the medical system. Until this can be established, no matter how sick she is, she will avoid seeking care and will continue nonadherent.

Comment #6

There were a lot of challenges to working with this patient, many of them systemic. I appreciated the way you wrestled with your clinical predicament - do you just abandon your patient to her false beliefs (and their potentially life-threatening consequences?) Or do you try to coerce her to recommence her meds?

Wisely, you recognized that the "meta-problem" worse than any of her other diagnoses is lack of trust in the medical system. Unless this is rebuilt she will continue to be lost to follow-up and nonadherent to treatment plans no matter how skillfully devised. You had the great insight that giving her something she wanted before she left the clinic might be a first step to building back this trust.

You also noticed that when the PA, whom the patient trusted, was in the room, the patient agreed to restarting one of her medications. So I agree that the vest thing to do is not succumb to your own frustration, avoid blaming the patient for attitudes and behaviors not completely in her control, and

go for the small victories. In the end, they have the best chance of paying well, both for the patient and for you

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Comment #1

I'm sure the issue of weight loss was handled in a sensitive, nonjudgmental way. There is still so much fat-shaming in our society, despite fat acceptance activism, that physicians must be especially careful to approach this subject with care.

Comment #2

Very perceptive. The RESIDENT might have been talking medically, but importantly the patient heard the information within the context of societal judgment.

Comment #3

Good for you. Your human instincts told you that the physician's role was to do more than inform the patient of her options and let her think about it.

Comment #4

This is a profound awareness. Indeed, doctors have to do very hard things - break bad news, set limits - and cannot turn away from these responsibilities. Telling patients only what they want to hear lacks courage and can even collude with bad or dangerous behaviors. But HOW you do these hard things is what makes a great doctor. When you can approach hard interactions with empathy and compassion, you make them easier for the patient and for yourself.

Comment #5

This was a terrific essay. You read the room (and your patient) so well, perhaps with more sensitivity than did your resident. You recognized underlying the story about PCOS, OCPs, and weight loss was another more troubling story that had captured your patient - "I am fat therefore unworthy." Rather than simply outlining her medical choices, you took a little extra time to put her suffering within the societal structural context where it belongs. I am sure that this follow-up conversation will help her make the best choice that supports her wellbeing.

Your reflection on hard conversations conducted with kindness and caring is impressively nuanced. It is not either/or but both/and. Hard conversations are part and parcel of medicine. If the physician does not learn to be comfortable with their discomfort, they will avoid hard interactions or engage in them with a kind of callous objectivity. Developing an emotional container through practices of

presence and centering large enough to hold both your own distress and the patient's fear/anger/helplessness is a hallmark of a truly outstanding physician.

Comment #1

Nice - rather than simply criticizing her for taking over the interview, you support her efforts to help her husband. You may not have expressed your strategy during the actual encounter as you wrote it here, so just keep in mind that, when possible, it usually is more effective to use a yes/and rather than a yes/but approach: it means you appreciate what the other person has done, and you have more to add that might help.

Comment #2

This is an empathic remark - it shows you are trying to understand where the wife is coming from. It doesn't make her behavior right - far from it - but it may give you a lever with which to move the situation in a more constructive dimension.

Comment #3

This sounds like an extremely difficult and frustrating encounter. It sounds to me as though the through line here is the wife, a healthcare professional, wanting to apply her work role to her personal relationship. As you astutely surmised, it sounds as though she sees herself as an advocate for her husband, and is behaving in this way to show she will protect him and help him (some of it may well be characterological and part of her personality structure). You are not easily going to change this couple's relationship dynamics, so a more fruitful option may be to try to enlist the wife as part of the team; i.e., find a role for her where she can feel useful but not cause additional problems. Respect her training as a nurse. Ask her what she would say to a family member who shared meds. Let her know you can see she brings a lot to the table, you want to figure out a way to work together. I have a feeling that once she feels safer and more valued, the encounters with this patient may become less chaotic and overwhelming.

Comment #1

Good question. There is no doubt it is harder to convey empathy through an interpreter; and you are dependent on the skill of the particular interpreter you get.

Comment #2

Absolutely. Despite the many communication barriers you faced in this interview, you were able to understand his frustration and fear.

Comment #3

Such a good insight. Your patient had lost trust in his doctors. He feels abandoned and on his own. Whether or not justified, this means that a lot of reparative work will need to be done.

Comment #4

Absolutely the right course of action. The important thing is that the patient is suffering and despairing. Regardless of the cause, he needs to feel that his doctors take his suffering seriously and are carefully monitoring his care. This is the reset the patient needs to build back trust in the medical community.

Comment #1

I agree - it seems like a terrible option to talk about EOL through an interpreter. But since it must sometimes happen, you want to do everything you can for the patient to get clear, compassionate information and feel as supported as possible. For example, if she wanted a family member present or a trusted pastor, to make this possible; to use nonverbal language, such as physical gestures, body posture, tone of voice, to convey your caring.

Comment #2

To me, it is always appropriate to be moved by your patient's suffering and to express this however is natural and meaningful to you. Of course, you never want your expression of grief to become center stage; but in asking many family members and patients how they felt when a medical student, resident, or attending shared tears, almost invariably they reply that they understood this as a sign of caring and were appreciative.

Comment #3

I agree, the patient must have felt a great deal of trust and nonjudgment in the team to make this inquiry about death with dignity. I hope she was able to have the death she wanted.

Comment #4

this was a moving essay. It sounded as though the attending skillfully overcame as best they could the language barriers and conveyed both very difficult information and a caring attitude well.

I also wanted to comment that I know students are sometimes embarrassed by showing tears or even crying in front of patients and family members. I disagree. While you don't want your own sorrow to dominate the situation (on the rare occasions this happens, it may mean that you are crying not so much for the patient as for yourself and that something in the patient's circumstances has triggered personal issues, which should be addressed with friends, family, or counselor), in fact feeling something in response to your patient's plight just makes you human - and it is something usually greatly valued by patients and families.

Finally, death with dignity is a difficult topic about which not only patients and families but also doctors have different feelings. What's important, as your team knew, is to respond respectfully and helpfully in an attempt to honor your patient's final wishes.

Comment #1

This does sound very difficult, the whole situation feels somewhat out of control. I don't necessarily think that, because the patient was "screaming obscenities" at you, that you had failed earlier to establish rapport. Rather, the patient had reached her limit and was no longer able to control herself because of severe pain. This is stressful for everyone, but also understandable. Her mental health issues were likely a contributing factor.

Comment #2

interaction was becoming unsafe, and given the patient's mental health history and escalating behavior, bringing in someone with a little more experience was an excellent decision.

Commnet #3

And again, I do not doubt that you had a genuine connection with this patient. It is just that her mental illness, her pain, and her fear overcame the relationship. Maybe the rapport you had saved you from getting punched, who knows?

Comment #1

This was certainly rude on her part. This is a possible explanation not an excuse, but she may have been asking for the added "expertise" of the attending in an attempt to modulate her own anxiety.

Comment #2

I wonder if you considered asking mom to leave the room while you were conducting the HEADSS exam. Sometimes this enables a reluctant teen to open up a little more.

Comment #3

I'm sure it was frustrating to have all these excellent points "commandeered" by mom, but at least it put them front and center in the conversation.

Comment #4

I'm glad you were able to find empathy for the mom. She sounded pretty controlling and intrusive. But as you realized, she was also frightened and concerned for her son.

Comment #5

You are also empathetic to the son, who is clearly going through a lot, and indeed may be developing an eating disorder in response to these stressors. It's also possible the mom is managing her own stress by focusing excessively on her son.

Comment #6

I actually think you did quite a lot. If the kid really does have an eating disorder, then this will not be solved in a single visit, and the most important thing is to establish a connection and earn the trust of patient and mom. This was not that easy, but you made a good start.

Comment #1

It sounds like you and the attending worked very hard to ensure that the patient understood her situation and could make an informed decision.

Comment #2

For me, the tricky thing is always whether such decisions are "personal choice." Sometimes our patients are so constrained by structural factors and cultural misunderstandings that I worry what we describe as "personal choice" is hardly choice at all.

Comment #3

Of course this is correct, and when patients make fully informed decisions that go against medical advice, this must be accepted and in a way that still leaves the door open for a therapeutic relationship with the provider if the patient so chooses.

Comment #4

thank you for tackling this nuanced issue of patient autonomy. Of course patient autonomy must always be honored. At the same time, when we are dealing with cultural, linguistic, educational differences as well as often structural barriers to equitable care and intrapsychic issues such as fear, loss of control, and denial, it is sometimes hard to reassure ourselves that a patient's choice is really "informed" and freely chosen. Nevertheless, all you can do is make the best effort you can to empathize with the patient's perspective and make sure they do have a grasp of the situation. This can take time and patience, and sometimes you might be short of both. In this case, it seems like both you and the attending did all you could. It is a frustrating, helpless feeling when the patient refuses what you feel/know is in their best interest. At this point, it's important not to allow those feelings to deteriorate the patient-doctor relationship, so that despite differences you leave the door open to continued care.

Comment #1

Nice distinction - you're pointing out that there are factors beyond the patient's control that contribute to an unfavorable outcome and therefore make the encounter more challenging.

Comment #2

And this just shows that one size doesn't fit all, and that generic tools will only take you so far.

Comment #3

I wonder if this is a case where expanding the system might help - does this patient have any sort of support system? Anyone who can help guide him, especially with healthy eating and even some upper body cardio? If not, you might be able to access supportive resources by involving social work.

Comment #4

This is also a very fair realization. There is only so much you can do to help a given patient, and you are absolutely right that very complex histories rarely offer simple solutions.

Comment #5

Agree - patience and persistence are medical virtues not often emphasized in the educational process, but are nevertheless essential to clinical practice.

Comment #6

this is a very thoughtful and honest analysis of the limitations of clinical medicine. Sometimes you are not going to easily "fix" the problem; sometimes you will never completely solve it. But as you

point out, what's most important is to keep an empathic connection with the patient, and keep chipping away creatively at the problem.

I'm going to also suggest something about emotions. Your essay showed great emotional awareness, which is very impressive. It is completely natural and understandable for you to feel powerless, hopeless, helpless, sad and frustrated. These feelings show that you care about the patient. The danger of such feelings is that they are uncomfortable and sometimes may drive you in suboptimal therapeutic directions - for example, they may lead to giving up on the patient, blaming the patient, blaming yourself etc. None of these outcomes, while understandable, are helpful to your patient. So while it is helpful to recognize your feelings - we should always start where we are! - think about exploring other feelings, i.e., curiosity about whether there is a way to improve this patient's behavior; compassion for his suffering - and yours!; pride at committing to him etc. My point is that emotions can influence in negative and positive ways during the clinical encounter, so being aware of what we're feeling and investigating other ways of feeling can have a helpful result.

Comment #1

outstanding identification of two key communication skills, important in any interaction but especially so with a patient with a very different perspective on healthcare.

Comment #2

It sounds as though you did an excellent job of establishing trust which enable the patient to hear your perspective on his problems.

Comment #3

Absolutely great insight. A referral can feel like a brush-off or a "dump". Taking time to get to know the patient, especially if the patient may seek the help of western medicine at a later date, is important both in terms of human to human connection and to lay the groundwork for a successful referral.

Comment #4

Yes I believe the key word here is "together." How do you ensure you are on the same team when you are coming from very different places? A great part of the answer lies in listening with respect and flexibility.

Comment #5

You show great cultural sensitivity. And I like your term cultural flexibility. You demonstrated exactly that by demonstrating respect for the patient's beliefs and desires, as well as a sincere effort to understand him as a person. This is both the morally "right" thing to do and also ensures a more successful referral. A referral is not simply a slip of paper. A referral is a complex transition in which a patient, who is suffering and in distress, moves from one doctor to another. This move is often fraught. Will the patient follow-through? Will it be a long time before the patient can be seen? Will the new doctor accept the patient's insurance or see them without insurance? Navigating these and other questions will occur more easily if the patient has confidence that the referring doctor is acting in their best interest and is truly concerned for them.

Ultimately your essay is about establishing solidarity with a patient from a different background. That sense of "togetherness" is essential for any good medicine to occur.

Comment #1

I'm impressed that you were able to connect with this patient and win her trust so that she was able to share this critical issue with you.

Comment #2

And of course, this statement would deserve further exploration in a continuity situation, since it is unlikely that this patient has no sequaelae from this assault.

Comment #3

I really like that you phrased it like this, rather than for example as doctor and patient. I think indeed the connection was made on a human level, which would have been much less likely if you had remained fixated on your role as medical student.

Comment #1

Good observation. I wonder how you felt about this "family-style" visit. Was it confusing? Helpful? Complicated? Touching? All of the above?

Comment #2

This is really very sweet, although it probably complicates care since the American healthcare system is organized around individuals - patient and doctors - not really families.

Comment #3

Very interesting reflection - as above, American medicine is structured more individually but it is worth thinking creatively about more family-oriented healthcare systems such as are found in some other countries, where, for example, families are expected to move in and care for hospitalized patients.

Comment #4

Great conclusion. Family members are not always reliable sources of information and sometimes they have their own agendas, but you are absolutely right that their input is always valuable (even if only to learn more about how the family dynamics operate) and, as you point out, they are the patient's primary support system, so the more you understand them, the better chance you have of enlisting them to play a positive role in the patient's adherence to the treatment plan.

Comment #5

It can be a little overwhelming to try to "manage" a family-oriented patient encounter, but as you wisely point out, the family is usually the patient's most consistent resource; and even when there are significant family issues that make their involvement more problematic, it's far better to know about these things than remain in ignorance. As you conclude, your patient must always remain at the center, but making room for family input through respectful inclusion usually benefits both patient and physician.

Your point about individual- vs. family-oriented cultures is particularly well-taken. It is worth realizing that the way American healthcare is structured prioritizes individual medical encounters and individual responsibility for their own health; but this is not the only way a healthcare system can be organized. In fact, my belief is that it would make a lot of sense to incorporate more family elements in healthcare. We already do this to some extent (family conferences, palliative medicine), but right now family members are often made to feel that they are intruding when they seek to understand the loved one's medical situation. We could learn a great deal from experiences such as the one you had with this elderly couple.

Comment #1

It sounds like the physician was able to remain caring and kind, while not acceding to the patient's demands. This is the right balance, but as you say, does not feel great and can be hard to maintain.

Comment #2

What I'd say is that, in this case, it FEELS to the patient that the doctor is an obstacle to his wellbeing; but in fact the doctor is an obstacle to maintaining his addiction.

Comment #3

You are absolutely right, Gianna, this is a very uncomfortable feeling. You always want to feel you are supporting your patients and doing what is in their best interest. In this case, unfortunately, these two things are at odds, and you must choose long-term patient welfare over short-term gratification.

Comment #1

You did a great job of getting your patient to open up, tell you something of his story and share his values and priorities.

Comment #2

Yes, to an extent these seem like contradictory demands. What do you think is going on with this patient? For example, I wonder if he is grieving a certain quality of life. Partly he keeps going to doctors because he wants to reclaim it; and partly he resents the doctors he turns to because they can't restore his previous vigor. I'd be interested in asking him what his expectations are from all these doctors.

Comment #3

My view is you all did a wonderful job of involving this patient in a meaningful and proactive way. No one knows how to chart the path forward exactly, and the patient's voice certainly deserves to be part of this conversation. It seems to me that the team hear him very well and this was reflected in the plan.

Comment #4

This was an old old patient with a lot of medical conditions who also (I think) was mourning the loss of his previous level of vitality. The team was successful in listening deeply to the patient (and avoiding pitfalls of ageism in the process) and really hearing his priorities for the future, which consisted of emphasizing quality of life and time with family. By explicitly asking him his hopes for the future, you helped him take the first steps toward accepting that medicine might not be able to resolve all his problems and that a return to his former life might not be possible. Instead, you

focused on what doctors COULD do for him, and agreed on a plan that showed you truly heard and saw him. This is a beautiful example of shared decision-making at a point in life where many patients are excluded from their own story.

Comment #1

Yes, this is a very true observation; it is especially difficult, although not impossible, to comfort someone through an interpreter.

Comment #2

I am so glad you decided to use your very limited Korean to greet this patient. In my experience, patients appreciate it greatly when the provider speaks a few words in their language or origin, even if that is the limit of their ability.

Comment #3

Absolutely. What a great insight - with a few words you shift the expertise from student to patient, a welcome change, and this shift conveys, exactly as you said, both humility and respect.

Comment #4

I'm imagining you and your patient shouting our Korean phrases to each other. What a way to enliven the sterile hospital setting. More importantly, as you observed, by your willing to take a risk to put yourself in a vulnerable position (the position usually occupied by the patient), you demonstrate both your humility and your respect for the patient's language and culture.

I really appreciated your redefining language difference not as a barrier but as a bridge. There is the content function of language to convey accurate information, and for this you need a fair degree of fluency. However, language also has a process function, for example, to convey willingness to meet the patient on their own ground.

You handled this sad and distressing situation beautifully. Not only did you risk using your few words of Korean to establish connection with this patient, but by having him teach you additional phrases, you enhanced his feelings of efficacy and distracted him from his pain. Altogether, the very definition of a healer!

Comment #1

This sounds extremely uncomfortable for you and even more so for the patient. It seems that the attending prioritized teaching to the point of objectifying the patient and ignoring her distress. You were right to be concerned.

Comment #2

I agree with this. You are demonstrating what the attending should have, which is attentiveness to student education but within the context of prioritizing the wellbeing of the patient.

Comment #3

This certainly very dehumanizing on the part of the attending. Sometimes we have to learn what we can from negative role models.

Comment #1

This suspicion of the government in many vastly different communities - in many Black communities, due to historical legacy of racism in medicine, and government-sanctioned experiments like Tuskegee; in some Latinx communities with residents coming from countries governed by corrupt and ineffectual elites; and in far-right white supremicist groups that believe the central government is a Jewish conspiracy. Trying to get past these beliefs on an individual basis to provide optimal healthcare is a challenge but can sometimes be achieved with a lot of respectful listening and an emphasis on the patient's wellbeing.

Comment #2

Outstanding conversation! So impressive that this awareness of contextual structural factors could be part of patient care in a busy clinic!

Comment #3

This is so important. The foundation of all good healthcare is trust, and structural systemic racism makes this very difficult across race, ethnicity, and class; but not impossible. Clearly the patient had some trust in his physician; and she built on that trust to begin an educational process that ultimately could lead the patient to taking more steps to protect himself (and possibly his family and his community) from Covid.

Comment #4

what was exciting for me to learn about was how you and your attending processed this patient's misconceptions and mistrust at a broad systemic level; and then drew on that understanding to approach the patient in a way that acknowledged his fears while also suggesting alternative ways of thinking about the pandemic. The important ingredient is trust, which these days can be hard to establish across different groups (race/ethnicity, but also class, education etc.). Nevertheless, as your attending demonstrated, this is not impossible, and can lead to positive patient outcomes when the patient is respected, listened to, and not judged.

Comment #1

I love that right away you realized her distress stemmed from TWO reasons: 1) The scariness of a first baby and 2) the feeling that medical personnel were not listening to her. You may have been the first person to put this together.

Comment #2

Really?! "Assistant"?! This is inappropriate and unprofessional. You are a medical student and should always be identified as such.

Comment #3

I'm glad to see that the resident took the time to redo an explanation that should have been offered directly to the patient in the first place; and I hope his frustration did not come through to his patient.

Comment #4

It seems to me the patient was labeled "difficult" because she asked questions, was interested in her own healthcare, and wanted to be part of a conversation about herself.

Comment #5

I really like the way you analyzed your learning points so clearly and succinctly. This is a great summary about key principles of patient-centered care such as always including the patient in communications that are directly relevant to them and avoiding medicalese.

Comment #6

I've never felt comfortable with this analogy, as I feel a lot of what is wrong with medicine is that it is regarded primarily as a business, thus evaluated by the same criteria that a car repair shop might have. Nevertheless I take your point that the patient's satisfaction should always be a high priority. This is because patients who trust their doctors and feel cared about by them will express higher satisfaction and will be more likely to adhere to treatment plans.

Comment #7

this is a very perceptive essay - you saw things happening that apparently the resident missed. By labeling the patient "difficult," the resident blamed the patient for the tensions that existed and thus avoided taking any responsibility for the discomfort. In addition, the resident made some mistakes of omission (not speaking directly to his patient) and commission (using medical jargon as well as, importantly, not working proactively to put this young woman at ease and help her to feel safe during a major change in her life). Everyone makes mistakes, so we learn from each other in this way; and it sounded as though, thanks to the patient's assertiveness, the resident was given an opportunity to correct his. My hope is that the lessons you extracted so easily from this encounter imprinted themselves on the resident's heart and mind as well.

Comment #1

Such an important point to make, thank you! Psychiatric illness is in the brain but it is also in the society.

Comment #2

This is important to recognize - how might you work with your own emotional "paralysis" to ensure that you are still available to care for your ptients?

Comment #3

It is true that words cannot materially change a person's circumstances, but you might be surprised how just being a respectful and attentive witness to another's suffering can be very therapeutic.

Comment #4

I'm so happy to see you recognize that "mental illness" is a multifactorial problem and that some of the contributing factors lie in the racist, oppressive environments in which people have struggled for generations. This reality cannot be overemphasized because it leads, as you insightfully observe, to multifactorial interventions that acknowledge the contributions of structural forces outside the patient's control.

I also appreciated your acknowledging your sense of "paralysis" in the face of patients' tears and distress. It is very understandable to feel helpless and at a loss for words. But as you note, acting as a respectful, humble, and diligent witness of another's story can be surprisingly therapeutic. It is actually rare that we can have our stories truly seen and heard - when this happens it is a great gift!

Comment #1

I have very limited experience in this area, Jessica, but I think pts who have truly made up their mind that they want to end their life because of terminal disease/unbearable pain are able to state this.

Comment #2

This is such a heartbreaking story, thank you for sharing. By simply eliciting then listening to her story, you were able to uncover not only her immense suffering, but also her depression, which might be treatable. This is certainly an encounter worthy of tears.

Comment #3

Yes, this is a significant problem in many communities, including Asian/Asian American. The importance of destigmatizing mental illness cannot be overemphasized.

Comment #4

Without understanding what an illness means to a patient, it is very hard to treat them adequately. Their cultural views are always relevant and deserve attention and respect.

Comment #5

It's wonderful that this story had a happy ending. It's also nice to hear how the presence of the interpreter made a big difference in the pt's trust level and her ability to open up.

Comment #1

It is so distressing that there is now so little trust in the expertise of the medical community that a friend's anecdotal experience (which, even if accurate, was likely not due to the vaccine) suddenly counts as much as the physician's counsel.

Comment #2

Outstanding that you realized this was an important goal of the encounter - before discussing vaccine vs. exemption, the patient had to feel safe enough and have enough trust in you to believe you were on his side.

Comment #3

Also good awareness. Whatever misinformation or disinformation people are clinging to, everyone is under a great deal of stress and experiencing high levels of anxiety and fear. People want to feel safe, and it is the task of the physician to help them toward achieving a calmer, less labile state of mind from which to make life-changing decisions.

Comment #4

These are extremely difficult conversations especially because there is so much at stake. I admire the way you and your attending/resident kept calm, avoided emotional escalation, and tried to provide reliable information to your patient. Based on his response of at least listening, I infer that you did this very well, perhaps even slowly getting him to reconsider his assumptions. I understand how frustrating it can be to have to rebuild trust with patients over and over, but there is no alternative to working toward consensus of how best to safeguard the nation's health.

Comment #1

This seems like a great example of doing the right thing even when it did not strictly follow the letter of the law. I can only imagine what might have happened if the patient had returned to his care facility; or had ended up on the streets, given his compromised impulse control and overall mental status.

Comment #2

And as too often happens in our bureaucracies, this seems like a decision that would likely not benefit and might put the administrators/residents of the care facility at risk, but conforms to the legal guidelines.

Comment #1

You handled this very well, Justin. It must have been frustrating to hear this litany of complaints especially when it sounds as though her doctors had been trying to help her.

Comment #2

you did a great job of using education to change the patient's mindset. She was certain that she had cystitis and certain that the solution was a "better" antibiotic. So your task was to persuade her to see her symptoms differently. This can be very hard to do, and the obvious care you took clearly made a difference. You did not argue, you did not condescend, you showed sincere interest in her

wellbeing, and demonstrated that you wanted the best for her. You worked together as part of a team. This approach, as well as the content of the patient education, was likely responsible for her shift.

Comment #3

Great point! Over the years, I've seen many physicians I greatly respect ask permission before plunging ahead - with the PE, with patient education, with EOL discussions. It invariably makes the patient feel respected and valued.

Comment #2

you showed a lot of empathy and skill in handling this difficult situation. I think you reached exactly the right conclusion: always, but especially in tense or "stuck" encounters, listen to the patient. Most of the time, they will tell you what they need. In this situation, you patiently took time to slowly and carefully explain your thinking, and why a 4th antibiotic was not in the patient's best interest. Even though the patient was not initially behaving as part of a team, you acted AS THOUGH she were, and this eventually won her over. Probably this took a little more time than simply treating this as a case of patient autonomy (if she rejects our medical recommendation, there's nothing we can do), but I guarantee it saved time and expense in the long run, as well as prioritizing the patient's health. Nicely done

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Comment #1

I appreciate your worries about whether you handled this delicate situation well. You showed excellent awareness of some of the differences between you and the patient - cisgender, white - that might make it more difficult for you to hold the patient's trust. That's a valuable first step.This is a tough call. More participants (like an interpreter) can make discussing sensitive matters such as sexual practices more difficult. On the other hand, if there is a language barrier, this too will complicate things. On balance, if the patient's English seemed solid and she declined an interpreter, then you probably made the right call, although it felt awkward.

Comment #2

These situations are certainly uncomfortable, and sometimes it makes sense to just move on. However, I think in the second example you had a good role model for how to set a limit on racist behavior that is not acceptable within our healthcare institution. Such limits can be set compassionately and gently, without shaming the patient, but also clearly and firmly.

Comment #3

Sadly, I do agree with this comment. As you move up the medicine hierarchy and have a little more control over patient flow, sometimes you find you can circle back (on inpatient) or make a note to pursue a topic such as health beliefs (in out-patient), but there is no question that the current healthcare system has other priorities than cultural sensitivity and structural awareness.

Comment #4

your essay raises many excellent issues about the intersections of culture, race, racism, and medicine. First is the difficulty of communicating about sensitive topics (or any topics!) across language and culture. Second is the awareness of our own limitations as providers grounded in our personal biology, background, and histories. Third is dealing with internalized racism in patients. And fourth is how to elicit patients' values, expectations, and assumptions about health and healing in the 7 or so (according to some studies I've seen) minutes you have for an encounter. That's a lot to be thinking about, in addition to the biomedical needs of each patient.

I actually think you've come to a very wise position. You cannot practice the most perfect ideal of medicine with every patient (then you'd probably only have a couple of patients in your practice :-)). But you can be respectful, caring, attentive to cues about histories and communities, and committed to making the life of each patient a bit better. Any patient who experiences this sort of care will feel fortunate in their physician.

Comment #1

Ouch! This is an unfortunate outcome. When care is delivered by multiple providers, there is a definite risk that the patient will feel they are getting conflicting information. It highlights the importance of good communication between providers about treatment plans.

Comment #2

This is also a problem. Decision-making in healthcare is a delicate and often complex process and, despite the difficulties, sufficient time needs to be allotted. Time may be short, but the patient needs to feel that she has all the time in the world.

Comment #3

I like your incorporation of the term patient-centered. We talk a lot about patient-centered medicine, but too often what is really being practiced is physician-centered medicine - ie., medicine that prioritizes the convenience, needs, and authority of the physician at the expense of the patient experience. It is not easy to resist these institutional trends, but especially at critical moments, such

as this patient faced, the highest priority of the physician should be, exactly as you state, that the patient feels supported and cared for as she attempts to navigate a difficult decision-making process.

Comment #4

you did an outstanding job of identifying two major factors that influenced this patient to leave before completing her visit. She clearly lost trust in her physicians and might never return to clinic. As you point out, lack of continuity was a significant contributing problem. In a training program, it is not going to be possible to always see the same provider. This being the case, programs should make special efforts to ensure continuity of communication and treatment plans. Secondly, it is a cardinal sin to make a patient feel rushed during the decision-making process. When a patient feels hurried, they may easily conclude that they are not "cared about," that they are a "problem" for the doctors and staff to "solve" as quickly as possible. None of this is conducive to good patient care, and may easily result in their vacillating about their decision; or as what happened here, leaving medical care entirely. I appreciated your highlighting both these issues and recognizing their value to optimal patient care.

Comment #1

Comparing these two agendas is instructive. The attending's goal was to set limits on inappropriate, distressing, and scary behavior. The father's goal was to let this latest round of doctors know that he and his son were still enduring great suffering, and felt that nobody really cared about helping them. Neither agenda is wrong, but each is insufficient in and of itself. Dad needs to not collude with his son in enabling bad behavior; the physician needs to recognize that the patient is acting out probably partly because of his psychiatric conditions and partly because he feels he's out of options. He feels very frustrated and helpless, so acting out seems to be his only choice.

Comment #2

This is also a really great awareness. Sometimes doctors may see patients stereotypically as merely representatives of a group; but this depersonalizing can go both ways: Patients can see doctors not as human beings but "white coats," all interchangeable and all equally indifferent. One way to minimize this (although obviously not in this crisis situation) is to allow your humanness to be part of the exchange. It's easy for medicine to become robotic and that means the physician as well. Trying to connect on a human level with the patient, sharing a little of who you are sometimes helps.

Comment #3

Of course you do not deserve such abuse. And perhaps none of the patient's previous doctors did either (or maybe they did. It can help to remember that patients are often scared, helpless, feeling out of control and sometimes lash out not because you or anyone else has done something wrong, but just because they need to punish someone. This is an explanation, not an excuse, but it can help you reframe their anger). If your patient had been able to see you as first-gen student who wants to change the world..." he might have been able to set aside his own frustrations just a little and treat you as he wished he had been treated by the healthcare system.

Comment #4

This sounds like a very difficult encounter and understandably so. You and the attending were subject to abusive language and threatening behavior. This is never okay,and setting a limit on such acting out is entirely appropriate. It's worth keeping in mind that HOW you set limits matters. It is possible to draw bright lines with patients from a place of compassion and care. This psych patient has multiple diagnoses that affect his mood and behavior. His elderly father has lived for 40 years with a son with ASD. Rightly or wrongly, they both perceive that the medical system has given up on them, if it ever really cared. You and the team unfairly took the brunt of their anger, helplessness and despair. But underneath this bad behavior is a larger story of despair and that deserves being addressed as well. If it had been possible to de-escalate the situation, then perhaps doctors, patient, and family could have had a conversation in which everyone's humanity was recognized

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Comment #1

Yes, this is clearly a concerning situation. Imagine how overwhelmed this mom must be trying to care for 5 kids with autism, as well as having insurance problems. It is so important to have a comprehensive picture of what is going on at home!

Comment #2

Thank you for formally noting the de-identification. It helped in reading your story that baby was identified with a name, but glad to know it was a place=holder.

Comment #1

I wonder what you did to earn her trust in this way. It is a heartbreaking situation, but I'm confident it helped her that she could process some of her initial emotions with you.

Comment #2

Yes, I understand why you offered these options; and sometimes counseling or therapy when facing end of life is both necessary and helpful. At the same time, however, you want to reassure your patient that there is nothing "crazy" about her feelings, that facing one's own mortality is extremely challlenging emotionally.

Comment #3

Absolutely right - and anger is also a perfectly normal and understandable emotion. Normalizing your patient's feelings and giving her room to express them, and thus to become familiar with them herself, is hugely therapeutic.

Comment #4

This feeling of helpless is not uncommon in medicine. From my perspective, you gave your patient exactly what she needed - someone she could be with, talk with, and express her feelings with. You were not a therapist, nor did she expect you to be. I suspect in this moment she did not need an expert, she merely needed another human being to witness her shock and anger and grief.

Comment #5

You are probably right about this - and a little emotional distance is not a bad thing, because it can help you stay focused on the patient. However, if your intellectualization is so strong that it closes your heart to the human tragedy your patient is experiencing, then you've probably taken it too far. I think, however, based, on her reaction, that you got it about right.

Comment #1

Of course, despite Elizabeth being delusional, delirious and agitated, you do want to determine whether there is any truth in this accusation. Unlikely, but possible.

Comment #2

Excellent awareness of your own emotional state in response to the patient's distress. Think about what is your goal in this situation? Assuming her medications are appropriate, you hope to calm her and reassure her. If you are able to do this, even imperfectly, you will have given your patient important support during a very difficult episode.

Comment #3

your essay is a really interesting reflection on what happens when we are in a situation we can't "fix" or "solve." Of course, naturally at first we feel helpless, out of control, maybe frustrated or anxious. It can help to ask ourselves, since I can't "fix Elizabeth's delusions, what CAN I do for her?" Realizing that there are still things you can give her can help your own feelings of helplessness and inadequacy. In this case, you came up with exactly the right answer - "listening, caring, and being present." I hope at the end of this encounter, not only was Elizabeth's distress alleviated, but your own as well!

Comment #1

Your approach is a creative one. Rather than argue about the diagnosis, you looked for common ground and found it in healthy eating. This is an excellent start. Your observations about diabetes being "taboo" are also intriguing. I wonder if you were able to ask the patient and mom whether were so adamant in their denial. This might help you understand where they're coming from. I imagine that diabetes is a very scary term to them and knowing that would be helpful in future discussions.

Comment #2

That's also helpful information. So it's not diagnoses in general they have trouble with, but specifically diabetes. This makes me curious as to why this is so.

Comment #3

I appreciate your empathy for the family's fear and suffering. It would be easy to simply label them as "in denial" (which they are) and move on to a more receptive patient. Instead, through empathy, you begin to understand the barriers that prevent them from accepting the diagnosis. This is an essential step toward reducing their fear.

Comment #4

I admire that you started where the patient and family were, rather than try to start from where you were. Having a chronic disease is not a static condition - the disease will change and so will the patient who has the disease. Eventually (e.g., when the patient needs to start medication or insulin injections), the patient will need to accept that he has diabetes. But over time, his physician can move him supportively toward admitting this diagnosis and learning to live with it proactively.

Comment #5

I especially liked your bold move not to engage with the patient around diagnosis but to find common ground instead. You (and your attending) also did an outstanding job of probing the "why" of the patient's and mother's reluctance to accept the diagnosis of diabetes, rather than judge it. By

working with the patient over time, the physician may be able to reduce his fear of this disease and help him feel empowered to take active steps to manage it. This is the ability to take the long view in medicine, and it can be very useful depending on the type of problem and the type of practice. It is especially relevant to family medicine. As you demonstrated, it takes a lot of humility and a lot of wisdom to start not where the doctor is but where the patient is. You are way ahead of many practicing physicians. Just don't lose that ability!

Comment #1

It's interesting that this desire to "interview" a perspective physician generated uh-oh looks. Of course, this could be a sign the patient is demanding, hard to please etc. She could also just want to ensure that her continuity doctor, who she will hopefully have a long-term relationship with, makes her feel comfortable and safe. It could be nothing more than the patient equalizing the power dynamic just a little.

Comment #2

It's true that the patient's perception is not necessarily objective. But whether or not she was ACTUALLY getting passed around, the fact that this was her subjective experience is cause for concern. While it is true that some people can never be satisfied, it is also true that although health professionals' might care on the inside, if this doesn't get conveyed through language and behavior, the patient won't know these feelings are there.

Comment #3

If you think about it, there is nothing inherently terrible about patients wanting to "interview" their prospective doctors. (It is not at all uncommon for people to "interview" psychotherapists to determine compatibility of philosophy, style etc. before making a commitment to care). Asking to "interview" a doctor might be indicative of a "difficult" patient, but it might also simply be a sign of a patient who wants a doctor who will listen, be an advocate, and be fully committed to her care.

I was especially struck by your observation about "passing the buck" in healthcare. I have witnessed many incidents of this behavior, usually in inpatient settings. It is not so much a sign of caring, but a consequence of an overloaded healthcare system where everyone feels overworked and burdened. It is a relief to think "someone else will handle this problem," but unfortunately it means often the problem simply falls through the cracks. No wonder that sophisticated patients want to ensure that

they will have doctors who are ready to speak and act on their behalf, even under difficult circumstances.

Comment #1

Yes, of course I recognize each one of these scenarios and they are challenging. Medicine experienced from the inside is more complicated than medicine seen from the outside!

Comment #2

Sometimes passive resistance can be even more difficult to address than angry or rude behavior because it's harder to confront - it kind of just evaporates when you try to grab hold of it.

Comment #3

Sometimes it can help to turn the tables. You know, "Hey, I'm all out of ideas here. What would you suggest?" Not foolproof by any means, but what you're looking for is a way to get patient buy-in.

Comment #4

It is probably true that there are some patients who really "don't care," but more often it's the case that the patient hasn't prioritized their health in the same way the physician has; or the patient feels hopeless or discouraged; or the patient has more immediate problems that are preoccupying them. Whenever possible, it's helpful (through MI!) to try to figure out what underlies that "not-caring."

Comment #5

Good insight, but I don't think it's all that obvious. The traditional physician's role is to "tell, tell, tell" patients what to do, so you have to be flexible and think outside the box to break this pattern.

Comment #6

These can be really effective questions because they force the patient into a more proactive role, and out of the negative position in which he's become comfortable.

Comment #1

Interesting. Is this diagnosis especially prevalent among this population?

Comment #2

I wonder does Korea offer some form of universal healthcare?

Comment #1

Good awareness. Many overweight patients will not seek medical care because they feel humiliated by the mandatory weigh-in. Often this process can be negotiated so that it is conducted in a more private manner or done away with entirely.

Comment #2

Excellent point - it is a model that blames the patient rather than takes responsibility for not being more effective in helping them.

Comment #3

Very perceptive. There's value in forming expectations for how a patient encounter should proceed, but you also have to have the flexibility to shift gears if circumstances require it - as you so clearly recognized they did in this situation.

Comment #4

I like your use of the term "co-devised." You're saying that your patient was an active partner in developing her own treatment plan, which maximizes its chances of success.

Comment #5

there's a lot to like in how you handled this patient encounter. Right away you were proactively thinking about your patient, which was admirable. Then you anticipated that a "routine physical" could engender discomfort and anxiety because of the mandatory weigh-in. You demonstrated empathy not judgment for your patient's struggles. Further, when she reflected on her mother's recent death, you recognized that you needed to shift the nature of the interaction. In doing so, you demonstrated respect for the patient's ability to play a significant role in guiding her own health.

Everything about this interview shows a patient-centered approach that treats the patient with dignity and caring. This is what we should all strive for in every patient encounter; and it's admirable that you hit each note so well.

Comment #1

I am so admiring of the way you reframed the patient's arrogant, belittling behavior and recognized it as an opportunity for bridge-building. This is often easier said than done, and requires managing initial limbic reactions, which you seemed to do very well.

Comment #2

This sounds really skillful - by understanding what he valued in his own culture, you were able to find common touch-points between your culture and his.

Comment #1

An important check, since even a challenging phrasing or tone of voice can influence the entire encounter.

Comment #2

Sometimes the patient is challenging the medical student with this question; sometimes they are trying to reassure themselves that they are going to get good care; sometimes both. How do you think this question might be handled? Ignored? Addressed defensively? Addressed with enthusiasm in an attempt to shift the tone? Many possibilities!

Comment #3

Wow, this is a terrible situation and a difficult ethical dilemma as well. If the abuse is ongoing, or even if Patient B feels threatened or fearful, given the past history it should be reported. This will disrupt the therapeutic relationship with Patient A, but it is not violating patient confidentiality because the disclosure did not come from patient A, Furthermore, in cases of abuse reporting supersedes confidentiality.

Comment #4

Yes, clearly you were not personally "responsible" for this difficult interaction, but rather the "victim" of this patient's biases and prejudices. It raises the question of how to deal with misogyny in patients. How might you address this? Or would you?

Comment #5

I agree that the most important goal in care is to ensure Patient B's safety. Although of course it is true that you have a professional obligation to provide care to all patients, not just ones of whom you approve, patient A is engaging in behavior that puts patient B in danger and this should be the immediate focus of intervention.

Comment #6

Your perceptive essay raises many complex questions: 1) How do you address sexism in patients? 2) What are your responsibilities in a situation of abuse? 3) How do you balance conflicts of interest when caring for multiple members of the same family? My short answers (which may not always be the best answers) are 1) although you have certain responsibilities as a medical professional, these do not include absorbing abusive behavior. You can remove yourself situation or respectfully challenge the patient. Ideally, as a medical student, your attending will protect you. 2) Your first obligation is to keep your patient safe - this includes providing shelter resources or coming up with a departure plan and, if appropriate, reporting abuse 3) Family Medicine can be a minefield for managing potentially conflicting relationships. A good guide is to respect patient confidentiality so long as it is not doing active harm to others; but to encourage as little secret-keeping in families (unless age appropriate etc.).

Your essay had lots of interesting dimensions to it. Thank you for sharing your awareness of the many facets of this encounter.

Comment #1

Yes, yes, and yes. When healthcare is mediated by insurance companies, it is the poorest and most vulnerable who suffer the most.

Comment #2

I don't know if this patient was actually seen at FHC, but I have personally seen many docs there go to the mat with CalOptima/MedicCal on behalf of their patients. It is unconscionable that this situation persists. She needs an advocate.

Comment #3

This is the literal definition of moral distress - knowing the right thing to do but unable to do it. Although the real victim here is the patient, it is also true that these situations have a tremendously demoralizing effect on physicians, medical students, and other health professinals.

Comment #4

I am in complete agreement with everything you write. The question, I think, becomes, where do you go from here? What do you do with your indignation, your guilt, your despair? In all my time in medicine, I have come across only two answers: 1) Fight like heck for your individual patients 2) do what you can to change the system. And never lose your empathy for patients - that would be the third answer.

The other thing I'd say is, yes, see the problem clearly. Don't pretend these terrible injustices aren't there, because that is just a form of denial. Decide what you can do about it. Then don't torture yourself with useless guilt. Being in healthcare in some ways makes us all complicit with an inequitable, unjust system that privileges some and penalizes others. But it's still a system that does good and saves lives. So make it better.

Comment #1

I love that you are tackling this disparity between you and many of your patients' views. These differences (whether about childbearing or other issues) are present all the time in physician-patient interactions; and unless the physician brings a level of awareness regarding such differences, the result can be mutual judgment, mistrust, and lack of understanding.

Comment #2

Excellent analysis about how cultural attitudes and factors might play into positive feelings about pregnancy at a young age

Comment #3

And an equally good assessment why, in the world you come from, an early pregnancy would be viewed as something near disastrous.

Comment #4

Awesome! I applaud this flexibility. Unless there is evidence-based concern about the future health/wellbeing of child and/or mother, their joy should be your joy.

Comment #5

I think there is also a difference between supporting a woman in her decisions around bearing a child, and helping her think through and prepare for some of the consequences.

Comment #6

What a lovely, generous conclusion. One cool thing about medicine is that you often encounter people who see the world very differently than you do. At the end of the day, you may not want to adopt their values, but learning from them is always worthwhile.

Comment #1

I'm not surprised, as the difficulties were not only linguistic, but also having to do with very different frames of reference.

Comment #2

I think you may be saying here that in such a situation it is easy (understandably) to become frustrated and impatience (neither of which "hurries along" the interaction). In fact remaining compassionate and patient-centered (a particularly useful approach in this situation where it is essential to try to elicit the patient's perspective - assumptions, expectations, understanding etc.)

Comment #3

Good for you - the daughter's emotional and language assistance was invaluable, but as your patient's doctor you always want to remain connected to your patient. This is not an aspect of the doctor-patient relationship you want to "farm out" to someone else.

Comment #4

These are excellent questions, and NO ONE has all the answers. But so long as you are able to maintain an attitude of curiosity and interest, rather than frustration, I think you will serve your patients well.

Comment #6

This sounds like a time-consuming and challenging encounter. I appreciate the care and effort you took with this patient, and your commitment to staying compassionate in the face of the difficulties you faced.

I also thought you were asking exactly the right questions. These are questions no one can answer completely definitively, but I think the key is to approach such encounters with humility and be ready to radically adapt the encounter to the needs of the patient. Eliciting the patient's understanding of her illness and her needs will help guide you in crafting your explanations and recommendations.

The key, as with much of medicine, is to sustain attitudes of curiosity, interest, kindness and compassion rather than succumbing to frustration and annoyance. Your patient needs your help, and it is up to you to figure out how to give it to her.

Comment #1

I love this conclusion! I think what you're saying is that, if someone could focus on the relative inconvenience of a catheter in the context of near death and disability, they have a strong life force.

Comment #2

It's wonderful that you were so moved by this "small" (from one perspective) encounter. I hope you never lose that quality, which is to be able to see things of great significance in the apparently trivial. A hundred times a day, patients ask doctors, when is my catheter coming out? What you realized was that, for this patient, this question put her on a trajectory toward life.

Comment #1

Although this was probably hard to hear, you patient gave you a gift. He explained why he is acting defensively. Now all you need to do, as you did, is discover the source of his mistrust, and what you might do to alleviate it.

Comment #2

If this is an accurate representation of a physician's comment, it is indeed horrible. It is uncaring and unprofessional, and sounds like the physician is abandoning this patient.

Comment #3

Nice comment. It's hard to be nondefensive in such a situation, where you yourself have not (yet!) done anything wrong. But at the moment you are the representative in the patient's eyes of a profession that has consistently mistreated him. So exactly the right way to respond.

Comment #4

I appreciate this comment. It's important not to let first impressions rule the day. Rather, take the time to find out the back story and you will almost always have more understanding of the patient and feel more empathetic. Although this was a rather long interview, it enlisted the patient in his own care and I guarantee you saved time down the road.

Comment #1

Especially in these times, when prejudice and anti-Muslim sentiment has run rampant, I think signalling that you admire and support a patient's religious observance is a positive act that will reassure and encourage patient trust.

Comment #2

I appreciate your sensitivity to being prepared to communicate either good news or bad news to the patient accurately and compassionately.

Comment #3

This was such a lovely essay to read! First, how wonderful that her pregnancy was viable. Second I admired your sensitivity to the importance of language and how important it was to give the patient the opportunity to communicate in the language in which she was most comfortable. Third, in reading your essay I too made the assumption she would prefer an Arabic or Farsi interpreter. The lesson here of course is - never make assumptions! Fourth, when patient and doctor share a language, the patient feels more comfortable and will provide a better history and more information overall. And fifth and finally, you are absolutely right that no matter what differences exist between doctor and patient and little digging almost always finds connections and often common ground. It is these discoveries that help patients develop trust in their physician. I valued your obvious concern for this patient and your evident joy that you were able to give her good news. I'm sure she felt these empathic, caring qualities as well.

Comment #1

Good point. It's worth considering that letting her talk for a little bit (say 2 minutes) might have been her way of establishing rapport.

Comment #2

Really excellent articulation of the dilemma - patient wants to talk and talk and you need to get your questions answered without falling too far behind.

Comment #3

Excellent analysis. Given her history of anxiety, this makes sense; and even though she had a good support system, she might also be experiencing loneliness.

Comment #4

This is absolutely true. The doctor becomes a source of social support - so the question is how can you fulfill this role to a reasonable extent without it impacting your other patient care responsibilities.

Comment #5

All excellent ideas - set an agenda, so the patient is more focused on the reason for the visit; GENTLE redirection, i.e., redirection done with compassion and affection, rather than annoyance and judgment; and finally letting the patient know she is heard by paraphrasing.

Comment #6

no question this kind of patient encounter is very frustrating. At the end it is easy to feel helpless, as though nothing was accomplished. But you (with the help of your attending) developed many great insights that will help you with older patients in the future. First, you realized that their social situations and psychological issues are going to affect the encounter. If they're lonely and anxious, they may talk a lot, to relieve anxiety and have some social connection. Second, you can be a kind, caring doctor and also set some boundaries on the patient. Redirection is an effective strategy, and it can be done with care and kindness (although it is easy to redirect with impatience and annoyance). Third, sometimes patients keep saying the same thing over and over because the physician hasn't given any indication that they've actually registered what the patient has said. Paraphrasing is the most powerful tool we have to reassure patients that they are, in fact, heard. It seems like it takes more time, but in the end it can save you time.

The encounter with the patient should not be a power struggle. The medical agenda is not necessarily right and the patient agenda, wrong. Both doctor and patient are trying to help the patient, although sometimes they go about it in different ways. Once your patient trusts you and believes you are sincerely committed to her wellbeing, it is more likely that she will accept your "shaping" of the interview, so long as she feels her needs will be met. For example, you can say something like, "Mrs. S, you know I love listening to your stories, you've had such an interesting life. You mentioned something about chest pain, and that worries me. Can I ask you some more questions about that to make sure you are okay and have many more years to play with those cute grandkids?"

In the end, if you can find something to like or admire or care about even with the patients who frustrate you, you will be able to more easily fulfill your goal of providing "the medical care they need and deserve."

Comment #1

I'm impressed with how carefully and thoughtfully you observed differences between the cultural/familial backgrounds of you and your pati

Comment #2

This is awesome! You managed to find common ground with your patient, and helped her feel safe enough, even with someone very different from herself, to discuss her significant psychological issues.

Comment #3

I love that your relationship with your patient led to therapeutic progress, including her receptivity to DBT and other treatments.

Comment #1

I agree with you, and you also deserve some credit for creating a safe atmosphere in which this patient felt comfortable being open regarding her previous traumatic experience and its ongoing effects.

Comment #2

A thoughtful and accurate conclusion - it shows you understand very well the important role family docs can play even when they will not be directly involved in every aspect of the patient's care.

Comment #1

Exactly - again, very empathic. If you are going to offer something that seems same old-same old, then you have to show the patient why this time it will be different.

Comment #2

Right, it's not that making a referral is the wrong next step, it's how it's done. If it feels like a brush-off, or a dump, and the patient just feels he's being passed from doctor to doctor, then he will be angry. If he feels he has a team working for him that is sincerely trying to help him, he may be more cooperative.

Comment #3

This is a really interesting observation, very insightful. If patient and doctor have different speaking styles, this may add to the confusion and frustration, as you point out.

Comment #4

Another great point. It is not that the doctor is a "bad" doctor. Rather, he wants to "do his best" for the patient, but is having a hard time connecting. I think if this physician noticed the things you've pointed out in your essay (the patient feeling like he was just being dismissed, the differences in speech etc.), he might become more empathic to the patient's plight and acknowledge his struggles.

Comment #1

It can be confusing to try to integrate family members into an encounter, but they are also an important source of information and often provide a different perspective than the patient, so it is valuable to have them present.

Comment #2

This is an important observation, Shaili. When a patient first encounters a provider, it is natural for the patient to be a little guarded or even skeptical. Here is a complete stranger to whom they are entrusting their body - that can be scary! It doesn't mean the provider has done anything wrong, but just that it may take a little time to build that precious connection.

Comment #3

Also agree - so it is worth thinking about what steps you can take to build trust and convey empathy across language and cultural differences.

Comment #4

And as you discovered working not only with the patient but simultaneously with family matters can prove more challenging still!

Comment #5

Very well stated. Don't be too hard on yourself. As you note, this is a learning process that takes time and experience. The most important first step is being aware of how essential it is to be able to work skillfully with an interpreter in a patient/family context. If this is a priority for you, the skills will come.

Comment #6

This is an awesome idea! I've known many wonderful docs who do exactly that. Reminding yourself about the individuality of your patient, their particular challenges, and the ways you connect with them helps personalize the encounter in positive ways.

Comment #7

one of the things many students find confusing about family medicine is that it often incorporates family members in clinical encounters. Of course, this is not unique to family medicine, but this specialty makes a special point of understanding and respecting the complex interplay between individual illness and its reverberations throughout the family.

You make some excellent points about the many barriers to establishing rapport - being an unfamiliar provider, confronting cultural and language differences, and figuring out how to integrate family members into the encounter.

I also appreciated your realistic perspective that as a third year student, you will not have yet mastered all the nuances of effective patient-doctor communication. You're right - it takes time and experience. I think the important first step is having the awareness of the importance of this aspect of medicine as well as the desire to develop your existing skills further.

I loved your idea of adding sticky notes in the EMR to remind yourself of key NONMEDICAL aspects of your patients - being able to refer to these is what will help you humanize your patient and make the encounter appear to be a personal as well as a professional interaction.

Comment #1

From this paragraph, it seems to me you made a significant effort to understand your patient's perspective, including her vaccine hesitancy, You identified relevant factors and did not judge or oversimplify the situation.

Comment #2

Of course, it is possible that for some reason she distrusted you PERSONALLY; but I suspect that what you encountered was the aftermath of centuries of structural injustice in terms of equitable healthcare. In this regard, you are probably accurate in sensing a level of istrust.

Comment #3

, I think it is precisely in these situations where we have "difficulty "grappling" with another's lived experience that empathy is especially valuable - and hard to achieve. It's easy to take personal offense, especially when all you're trying to do is be of help; but it is probably more constructive to acknowledge the historical (and present-day) contexts that make trust so difficult for certain groups of patients encountering the healthcare system. Your "empathy exercise" of imagining yourself in this Black woman's shoes was a very good beginning.

As a future physician, all you can do is attempt to build trust even under these difficult conditions. Sometimes it is helpful to overtly acknowledge issues that might compromise trust, such as racial differences between patient and provider, historical injustices etc. Other times, by persisting in an anti-racist commitment to your patient, you can earn their confidence. There are no easy answers here, but we want to focus not on our personal feelings of hurt but rather on how to make the patient feel safe and respected. That you were able to make this shift is very impressive.

Comment #1

his was a very appropriate request on your part, Sina. Generally speaking, third year students should not be delivering bad news; or if they do, it should only be after preparing with their attending/supervising resident and having their full support and presence.

Comment #2

I'm interested in how your attending accomplished this difficult task; and whether you thought they did a good job; and if so, why.

Comment #3

Every patient responds differently to this very difficult news. "A bummer" probably doesn't begin to encapsulate the meaning of the information the attending imparted, but then what does?! It's also interesting that the patient wanted to smoke, probably what caused his lung CA in the first place but also probably a source of comfort and consolation. I personally agree with the attending that, under the circumstances, the cigarette would likely do more good than harm. You were still right to ask if it was okay:-)

Comment #4

This was a very heartfelt essay. You did everything so well - first, asking your attending to break the bad news (not your role, unless you specifically want to attempt it, and then only after adequate preparation with your attending or resident); then, after asking permission, taking the patient for a smoke; and most importantly, when outside, staying with him and listening while he processed facing the end of his life. If the attending had not agreed to the smoke; if the patient had not been able to take a pause to collect himself while you wheeled him outside; if he had not had the comfort of a cigarette - he might not have been able to reflect on the news he'd just received. You and your attending handled this difficult situation very well; and your courage in bearing witness while the patient contemplated his own death was an act of both courage and compassion. Well done!

Comment #1

Good point. They are not "trying" to frustrate you, but the complexity of their situation can be, as you say, overwhelming. Thus the difficulty may reside in the situation more than in the patient.

Comment #2

What's really important about what you're noticing, Sophie, is that the physician will have all these emotions associated with this patient - feelings of being overwhelmed, frustrated, helpless. How will you manage these emotions so that they do not interfere with patient care?

Comment #3

Awesome. You are very perceptive - we expect patients to communicate according to standards set by the physician, but this is not usually how people talk or how they think about themselves and their circumstances. No question their circumstances can be very challenging, but by demonstrating caring, compassion, and sincere interest in their wellbeing, you can indeed be of help to these patients. Of great importance, as you realize, the physician will end up feeling good rather than frustrated knowing that you are doing what you can to heal your patient one encounter at a time.

Comment #1

Excellent method for achieving your goal. When patients feel judged or not listened to, they often choose not to return for medical care.

Comment #2

What a lovely essay. I appreciated your choosing not to engage in stereotypic thinking based on past information you had about the Romani. I also was impressed that you carefully observed the family for its strengths (loving, caring, attentive). Finally, I respected that you made a special effort to be non-judgmental in the hopes of establishing more regular continuity care for the kid. You adopted exactly the right approach - curious, interested, kind, and open-minded - which was validated by the same attitudes in your attending. This is how patients and doctors from different cultural backgrounds are able to develop trust and work together. Well done!

Comment #1

I wonder if cultural differences may have inhibited her speaking up to ask for clarification or to explain her inability to swim.

Comment #2

The concept of cultural humility can help you navigate culturally unfamiliar situations. When you relinquish the role of expert and instead position yourself as a learner, the greater the chances you will be able to build understanding and even connection.

Comment #1

Such a good insight. This patient is going through an incredibly traumatic event, and it is making her sick. Medicine could not have prevented it (although one wonders whether anyone in the medical community was aware of and tried to intervene to control this violent ex), but medicine - and counseling - can help support this patient toward better health and wellbeing.

Comment #2

It sounds to me as though this awful situation was handled very well. You addressed the dangerous blood pressure levels, while also identifying supportive services to help with the contextual issues. This is exactly what a good family doc can do.

Comment #4

Sometimes it is almost inconceivable what people endure! But it sounds like this patient was given exactly what she needed - the medical intervention to ensure she didn't stroke out; and the long-term support to help her address her grief and anger. You did a great job at looking at both the immediate crisis confronting you (dangerously high BP) and the social factors that contributed to this outcome. I think what can happen sometimes in medicine is that it is the immediate problem that gets all the attention, and the larger context is ignored. But by focusing solely on what can (relatively easily) be fixed or at least improved, the doctor does a disservice to the patient. The patient's need is not only to bring her blood pressure down into a normal range (the biomedical goal) but also to deal with her loss and grief. A good primary care doctor can help with both, as you and your attending clearly did.

Comment #1

This is obviously a very complicated situation, that is occurring all over the country, between frustrated and sometimes desperate health professionals and their patients. Unfortunately, there is no magic way to ensure the success of these exchanges. A few questions to think about: 1) In asking the patient to justify their reasons for refusing vaccine, what is your goal? Ideally, you want to come from a place of curiosity and concern for their wellbeing, rather than finding ways to poke holes in their convictions. 2) Humor has its place in patient interactions, usually when there is trust and familiarity so that the patient feels safe. In disclosing your own vaccine status, how could you share that information in a way that might be helpful to the patient? (e.g., explain you got the shot to protect yourself, your patients, and your family). As much as possible, the context for these conversations should not be judgment but desire to help. Admittedly, with the situation in which we now find ourselves, with colleagues increasingly burned out and falling victim to this terrible scourge, despite vaccination, it's hard to project this attitude.

Comment #2

We know that people who refuse vaccination do so for very different reasons. In Black communities, because of historical injustices, there is often widespread mistrust of official healthcare initiatives and unequal treatment of Black patients. Not all of these beliefs are accurate (the government gave Black people AIDS) but plenty are (Tuskegee, Black maternal mortality rates, mistreatment of Black pts with sickle cell disease etc.). Our best hope of achieving high levels of vaccination in

communities where suspicion of the motives of government interventions is prevalent is to find alternative trusted advocates such as religious figures, Black healthcare professionals, community leaders etc.

Comment #3

This acknowledgment of you is very touching and a tribute to the way you handled yourself in this fraught encounter. By doing more listening than speaking, by receiving his story (as you so clearly did), by respecting him as a person (while likely disagreeing with his decision), you laid the groundwork for a more trusting relationship in which eventually meaningful dialogue could have occurred had Mr. R not been discharged the following day.

Comment #4

I agree that it is a heavy lift, but I wouldn't despair entirely. The fact that even after one encounter, Mr. R voiced a positive attitude toward you and gave you advice to "stay true to yourself" suggests to me that with a little more time he could have seen you not as a representative of a distrusted government but as a young person embarking on life. He might not have regarded you as an expert or an authority, but if you had had time to talk with him about vaccination, he might at least have listened to you as he would to a grandson who had some knowledge he himself did not possess. It is true as individuals we are all swimming upstream in waters that have been racist and inequitable for a very long time (400 years in this country). It is also true that social justice can only truly be achieved through systemic change. In the meantime, it is still worth reaching out across these structural barriers to try to earn the trust of ALL your patients.

Comment #5

thank you for such a perceptive, empathic essay. You did a great job of not facilely judging your patient, but instead listened to him and respected his story. As you surmised, beliefs about exploitive government health practices do circulate in Black communities; and while many of these rumors are misinformed, unfortunately medicine has a strong racist history which fuels these beliefs. You are also correct that it is a challenge for an individual physician, particularly from a different racial or ethnic background, to be perceived as a trustworthy person. Motivational interviewing could be helpful in deciding whether he is even ready to engage in a dialogue. Always ask permission before embarking on this kind of sensitive topic.

If so, rather than joking about this something obviously so problematic for the patient, a better approach is probably to acknowledge the historical context that undergirds the patient's suspicions, treat the concerns seriously, listen and ask more questions. What are his community's leaders

saying about vaccination? What about his pastor? What are his family and friends feeling? Is there any part of him that might consider the vaccine under any circumstances?

Acknowledge it's a hard decision, and only then share humbly (rather than as the physician expert) that from your understanding the vaccine is safe and the best way of saving the Black community from the disproportionate number of deaths it's already experienced. Basically, you want to try to meet the patient where he is, and then motivate him with what he cares about.

Comment #1

Humor has to be used carefully. In the right context, always avoiding targeting the patient as the target, it can indeed defuse tension. But, as you saw, it can also make a bad situation worse. Use with caution!

Comment #2

This is an important observation. You are absolutely right that it is easier to be the observing armchair critic than the frontline actor. The key is to learn some of those "observational" skills into the ongoing action of the clinical encounter. Not easy to do, but also something that, like many things, gets better with practice.

Comment #3

thank you for this thoughtful observation. You are absolutely right it is easier to sit back and critique than to do in the moment. However, we can learn a lot from this observational position, as you so clearly did. Like you, it sounded like your attending did a good job of reading the room - and his patient - but approached the situation in a way that alienated rather than connected with the patient. Unfortunately, once doctor and patient end up on opposite sides, it is hard to effectively care for the patient. It's important to remember that engaging a patient about controversial topics is not the same as talking to your neighbor about such issues. First and foremost is trying to maintain a therapeutic alliance, regardless of differences. Personally, this seems very difficult around issues such as vaccination and masking, but it is still a worthwhile goal to aspire to.

Finally, in terms of humor, as I note, it is a tricky tool. Used properly, it can defuse tension and draw doctor and patient closer. But if the patient feels they are being mocked or their ideas are being belittled, it will backfire. So consider it as an arrow in your quiver, but only to be drawn out on occasions where you feel confident you and the patient have a solid relationship and humor helps bond you together.

Comment #1

My guess is that this was explained to the patient, but not in a way that she understood or made sense to her.

Comment #2

Very thoughtful concluding paragraph. I agree with you that, in addition to trying to see each interaction as a 1:1 encounter, it is important to recognize the systemic bias that has privileged some and disadvantaged others. One way this may manifest is speaking in ways that do not connect with your patients. I commend your commitment to listening and learning from your patients how you can best provide what they need.

Comment #3

you describe a very simple event but recognize its significant ramifications. Patients should not be subjected to procedures they do not understand - period. Often when procedures are explained and consent is obtained, the patient agrees without fully understanding, yet is too embarrassed or hesitant to clarify or express reservations. The physician thinks they've done their job, and treatment proceeds. Yet it is incumbent on the physician to communicate in ways that are clear and accurate without being patronizing or condescending. Respecting your patients, allowing them to be your teachers as you suggest, is a very good start at becoming the kind of doctor ALL your patients will trust.

Comment #1

This is a good example of imaginative empathy. It is always a good idea, if we can make the time, to check out our ideas about the patient with the patient so we can determine how well they match up with his lived experience.

Comment #2

Awesome! This approach sounds easy but can demand a lot from the team. Nevertheless, I agree that the patient needed to be seen, heard, and consoled where possible.

Comment #3

Yes, this is an interesting idea. If by "win" you mean have things turn out the way you think is right or fair, then absolutely. We might also think of a win as simply showing another human being kindness and compassion, which he might be greatly in need of. It might not transform him completely, but it might make him feel just a little safer and understood.

Comment #4

Absolutely, these skills are not easy to perform, but in the long run, they can actually save you time, help you feel good about yourself as a doctor, and ensure your patient gets optimal care.

Comment #5

There is no panacea that guarantees a perfect patient interaction, as you have discovered. However, your own behavior can definitely influence the encounter in a positive or negative direction. As you commented, listening, trying to understand, and remaining patient and calm are not easy to do in the face of a patient's hostility, avoiding an escalation of the situation is usually a beneficial strategy. You did not transform your patient into an angel, but you did help him become calmer and more cooperative; and you even got an apology out of the exchange! Clinical medicine is all about people who are feeling sick and scared. Often they are not their best selves, and sometimes they will take out their feelings on the nearest person who might be you. This does not justify bad behavior in any way, but can makes us feel a little more compassionate, and can help support our commitment to treating every person who crosses our path with kindness and empathy. You are your team did really good work with this patient. You should be proud.