AOD 2016-2017 ASSIGN 1

Persistent sexism among the VA population is appalling. We recently did a Schwartz Rounds on the Racist Patient, and the responsibilities (and rights) of physicians, nurses, and other staff in this situation. The parallels to sexist attitudes and behavior in patients are obvious.
One response, a very legitimate and sometimes an effective one, is simply to ignore such comments, as you did. However, if they persist, you may need to let the patient know that they are not appropriate and interfere with his care.
I can see both sides. Sometimes, depending on your perceived risk or level of discomfort, it makes most sense to withdraw, particularly if the pt's inappropriate behavior cannot be contained. On the other hand, it may also be important to demonstrate that you cannot be bullied into not doing your job, and to continue on. I think each situation is different. I do think it would have been very reasonable to explain to an attending (perhaps the doctor who had originally examined the patient) what was going on, and have that authority figure explain to the patient that such behavior was not acceptable. What I worry about is the perception of institutional collusion. If no one formally sets limits on the patient, it may seem as though the institution doesn't care about or doesn't take seriously such behavior.
Humor can be useful, if skillfully applied, because it is an indirect way of confronting the pt with his own behavior, rather than simply letting it slide by ignoring it.
Regrettably, as we see over and over again, sexism permeates all levels of society, and you are not immune even in the high status role of a physician.
Hi --. I can relate to this example, having many times been on the receiving end of sexist assumptions or inappropriate remarks. Your comments about X were very interesting - I think it is always hard for anyone not in another's shoes to really grasp their experience. I thought you handled this particular situation well, and have grown since. Your more proactive efforts to subtly but effectively challenge sexism (without necessarily severing the doctor-patient relationship) represent our best hopes for chipping away at this serious and persistent social prejudice.

Yes, this is the challenge. How can you advance your objective (which is essential to this pt's health) while respecting (although not agreeing with) his perspective.
So she also became "difficult" in her interactions with the team. Your awareness and empathy for her "caught-in-the-middle" situation is admirable, given how frustrating it must have been to deal with her as well.

--, you did a very impressive job in this essay of analyzing everyone's motives and perspectives - the pt's, the wife's, the team's, your own. It was a very delicate and problematic situation, and it appears you and your team handled it respectfully, patiently, and nonjudgmentally. The result was what you hoped for (still only the beginning of a long and uncertain journey for this patient) in that the team and the patient could finally establish a common agenda. Excellent work on the part of the team and excellent awareness of the dynamics on your part.

When something does not "make sense," instead of dismissing the pt as attention-seeking or somatizing, look for what does make sense. And listening for understanding - really nice phrase - is the best way to do this.
Excellent insights, --. You handled this situation beautifully. You have discovered that simply reacting to the first problem that presents itself (dysuria) does not necessarily lead to either efficiency or optimal care. Take time to uncover "the big picture" especially when the pieces don't seem to add up will often point you in a more relevant and productive direction. I really liked your term "listening for understanding." As you noted, this provides important insights and builds trust. Together, all this adds up to better patient care. Really well done.

I respect that you approached the nurses rather than simply ignoring them and likely internalizing feelings of resentment and anger. Looking back, I wonder whether you think there might have been other options for expressing your concern? Perhaps your first sentence would have been sufficient to open a dialogue?
There is very little attention paid in training to communication between doctors and nurses, yet much rides on the quality of this communication.
Absolutely - it is very easy for members of one "tribe" to grumble amongst themselves about the other "tribe"; much harder to start a conversation across interprofessional lines. That is why what you did is so admirable.
At least it is worthwhile to consider the LEVEL of confrontation necessary. Simply by challenging their in-group discussion, you are challenging them. It is worthwhile to think what is the least amount of "force" needed to achieve your goal? It is worthwhile to remember that you can always escalate, but it is harder to back away from a high level of conflict.

Again, in my view, you should be commended for having the courage to confront an unprofessional process. Could it have been nuanced a bit? Perhaps. But the most important thing is that you took an action aimed at resolving interprofessional differences.
I think your confrontation of these nurses' unprofessional chatter took a lot of courage. Might your remarks have been tempered a bit? Perhaps, it is hard to judge after the fact. I know for myself, it is always helpful to take a breath before confronting someone else, and to quickly think what is the goal I want to accomplish, and what is the best language to achieve this. I suspect that because of your strong yet appealing personality, you don't have to come on too strong for people to pay attention to you. In any case, in my view standing up for your team - and hopefully enlisting the nurses as part of that team despite the challenge you point out of differences in priorities between ED vs. ICU - is the right action to take.

When patients say they are feeling pain, they are feeling pain. It may not be the kind of pain they think it is; and it may not be alleviated by the kinds of treatment they are seeking, but their experience should always be considered as REAL.
This is a beautiful response. You realize that you went an extra mile because the patient demanded it (which was very conscientious on your part); but you were also moved to want to give this kind of attention to quieter, more acquiescent patients. Of course, if you went an extra mile for every patient, you'd pretty quickly circumnavigate the globe. But it's worth considering WHO gets this care and WHY, so you can make conscious choices about how to distribute this important resource, rather than simply reacting to immediate circumstances.
I appreciated the persistence and effort you showed with this patient. Involving his psychiatrist was an excellent idea - you don't always need to solve everything yourself, get help from others! You also concluded that suffering is suffering, although patient and doctor may disagree about causes and treatments. Nevertheless, acknowledging the patient's misery is a first step in establishing trust. Finally, I was intrigued by your insight that every patient deserves full answers and attention, even when they don't demand it. This was a really thoughtful awareness; and it will be interesting to see yow you carry this forward into your future patient care.

I was surprised and admiring to learn that you did NOT take your assigned vacation day to study for the Shelf but instead prepared the presentation your senior had required. That was impressive, but I stress not necessary. You deserved that day, and there would have been no shame in your using it. The system will always push you to give 110%. When you can do so graciously and with little personal cost - or especially when it significantly benefits a patient - this is a reasonable choice. It is also a reasonable choice to take care of yourself. As far as speaking up is concerned, I felt you were completely in the right. In my view, the resident handled this in an unprofessional manner and owed you an apology. It did not seem one was forthcoming; nevertheless you corrected the record and the implication that you were a slacker.

It is not always necessary to confront a situation head-on, especially a situation that will be of short duration and unlikely to be repeated. Sometimes a work-around is the best use of your time and will result in the best experience for you.
--, I really liked your creative problem-solving in this situation. There you were, in a strange environment, with little support, a fellow who did not want to teach, and a need to make the most of your limited time. Rather than expend energy discussing the problem with the fellow, who seemed pretty dismissive and is likely someone you'll never see again, you chose what Taoism calls "the way of water" - finding the path of flow rather than resistance. You enhanced your learning and avoided what likely would have continued to be an unproductive experience.

If the patient expresses that she is not ready emotionally to discuss this loss, that is one thing. But for everyone to ignore it might imply that no one recognized her loss. I do not mean to suggest that this was YOUE responsibility as the 4th yr on the team, but I do believe SOMEONE should have sat down at her bedside and asked what she was going through. I doubt that she could feel more "heartache" than she was already experiencing.
I couldn't have said this better myself, -- :-). You've got it exactly. Sometimes we avoid difficult topics with the excuse it will be hard for the pt to talk about it, whereas in reality it is because we ourselves are not comfortable or feel we don't know what to say. This is okay - in the presence of a fetal demise, who can be comfortable and what can be said? But witnessing to the patient's grief and guilt, as

you wisely note, will be an important part of her healing; and it should start with her doctors and nurses.
--, this was a really valuable and honest essay. You realized by the end that, in avoiding discussing the loss of her baby, everyone on the medical team was ignoring the essential fact of this patient's life. If the patient truly does not want to talk, she will tell you. But acknowledging that a terrible tragedy has occurred - and doing so nonjudgmentally, since mom is probably prepared for harsh judgment from the medical community that advised her to deliver at 37 wks - will be the beginning of her healing, and this should happen in the hospital, meant to provide succor and shelter to the stranger.

This is definitely one approach. Do you think this might be colluding with the patient in some sense, i.e., sending him a message that it was okay for him to demean you? What else could you do? Could you make the issue explicit? e.g., ask to explain the "understanding," to share your perceptions of his interactions with you, and to ask him did he think it was okay to talk to you in this way. This surfacing of his behavior might make him take more responsibility.
This is a really good observation. Many times, for a variety of reasons, patients "needle" med students or nurses (occasionally doctors) as a kind of test - will the doctor "hang in" with them? Usually, however, when the doctor persists graciously in care, the patient backs off, which did not seem to happen in this case.
I agree. When patients act in provocative ways, it is easy to react in kind. Not necessary, and rarely helpful. You can always choose how you wish to interact with your patient, and staying patient, centered, and compassionate can only improve the patient's outcome.
--, thanks for your essay. You are very thoughtful about what might have explained this patient's behavior - as you say, this was likely not about you, but about his own fear and loss of control due to his cancer; perhaps some element of drug-seeking; and as well, the possibility of a personality disorder. I'm impressed that, no matter how he behaved, you did not react to his negativity, and were always ready to be open to forging a therapeutic relationship.
I do want to counsel, however, that ignoring/absorbing verbal abuse and demeaning remarks is not the only choice you have. In a respectful, professional manner, you can address the issue directly - "You seem very upset with me. Can you help me understand what's going on?" You can also let the pt know that you'd like to develop a mutually respectful relationship focused on taking the best possible care of him. In

these circumstances, there is no one "right" answer, but you should have several options to choose from.

This is understandable, this is a "trivial" problem by medical standards. We can also think of it from the daughter's perspective: There is not much she can really do to help her father in his dire situation. All she can try to do is feed him (a highly symbolic act associated in most cultures with love and caring). Yet here in the hospital even that is beyond her control.
Excellent job. And never forget the power of "compassion-in-action." You could run down to the cafeteria and get a diabetes-acceptable snack for the patient to tide him over. Patient would feel less hungry, daughter would feel she'd fulfilled her filial duties, and you'd be out 5 bucks but you would have alleviated everyone's distress :-)
--, I very much respected the evolution you showed in this encounter from "what's the big deal of being a little hungry" to deep appreciation and understanding for what "feeding her father" symbolized to his daughter. This awareness enabled you and the daughter to find common ground and align your goals. By sharing with her that pt comfort was an equally important goal to both of you, you formed a therapeutic alliance with the daughter. She became a member of the team, rather than an annoying outsider.

This seems like a rather superficial solution to what sounds like a complex social problem - a way of placating the pt without really understanding what is wrong. If your mere presence exasperated him, removing you from the case may have been a necessary step. But I doubt it solved much.
Well observed - you capture these two perspectives perfectly. I still am not convinced that his pique was primarily with you. Rather, it seems to me you were the lightning rod for his anxieties and fears regarding his medical condition and his care.
I can understand this desire - and it is quite true that medical students are sometimes negatively perceived by patients who think they are being "pawned off" on inexperienced learners. Still I think this anger is a manifestation of a "safe dog to kick." The more serious source of their anger is likely to be distress and helplessness at their situation.

Hi --, how upsetting to have invested so much with this patient only to have him trash you as soon as he regained his communicative abilities. You were impressively empathic in understanding his perspective. Nevertheless, I wonder how effective it was to remove you from his case. Did he become a model patient? If so, well and good. But I suspect that your disappearance did little to alleviate his underlying fears and anxieties, or to resolve a problematic social situation. Still you exhibited wonderful forbearance and you certainly have earned that slightly longer white coat :-)

A very defensive response on your resident's part. You may have identified with the patient in some way - or not - but your confronting the resident had to do with your respect for the personhood of the patient regardless of her background.
This is completely understandable. However, let us hope that the response from the clerkship will be more educational than punitive. As you said, the goal is to help this person understand the moral wrongness and cruelty of such statements. If no one ever challenges him, how will he ever learn the consequences of his thoughtless statements?
--, this incident was truly horrifying, and you absolutely did the right thing in reporting it to the clerkship director. Thank goodness this individual responded with appropriate concern and support. I understand your feelings of guilt - "blowing the whistle" on a colleague. Yet had you not done so, this individual would have learned nothing and would consider his behavior acceptable and justifiable. I admire that you stood up for this patient, both in the moment and later with the clerkship director. This is a true example of patient-centered medicine. And hopefully, rather than simply being shamed, the resident will have an opportunity to learn why this is a highly unprofessional, uncompassionate, and inappropriate remark.

What a great question in a very tense situation. I really respect that you simply kept going, trying to understand what had gone wrong. And your patient told you. And you apologized and acknowledged that perhaps you had not fully been able to grasp the depth of her suffering. I'm imagining that this was a tough interaction, but it was also very valuable. You persisted despite the pt's hostility (which especially with some psych pts is often a test of the physician's level of commitment) with the result

that you were able to offer an apology and empathy tailored to her need. Very well done.
--, I admire your determination to connect with this patient, despite her angry rejections. Your ability to remain calm, to ask the patient to help you understand what had gone wrong, to have the humility to apologize and the chutzpah to try again to find the words this patient needed to hear . It is like finding the right key that will open the lock. Sometimes the pt is testing to see, will this dr. hang in with me; will they really care about me? You demonstrated that indeed you would.

There are several things I particularly like about the way you handled this: 1) Appropriate personal disclosure. Of course it is not always the right move to share your personal story. But I've noticed that when a patient/family member feels strongly that you "just don't get it," being willing to disclose something similar you've experienced causes them to see you differently. 2) The "we" language and team-building. Great sentence - we're all in this together. This is getting on the same side as the family, working toward something everyone can agree on - her comfort.
--, the way you handled this difficult encounter was truly outstanding (and your summary paragraph was a model of distinct distillation of all key learning points). You had a superb grasp of what was really going on in this exchange; and through empathy, nonreactivity, silence, personal disclosure, future orientation, bonding, and finding common ground you were able to transform hostility into cooperation. Very impressive all around.

You have probably seen this split before: cooperative, pleasant patient and aggressive, questioning family member. In this dynamic, the patient is "good," to assure the support and goodwill of the doctors; while the family member shows love and duty by "advocating" (albeit harshly) at every turn for the loved one. It is not an easy dynamic to deal with, but it sometimes helps to realize that the family member is enacting a role that, in this family system, represents being "good" as well.
It helps to remember just how helpless and out of control people feel in the hospital - both pts and family members. Sometimes the lines they draw in the sand seem ridiculous, but they are usually an attempt to regain some sense of control and to demonstrate they are doing all they can for their loved one.

--, this is true, and perhaps the most important lesson. Medicine is really not primarily about pleasing people, but about enhancing their wellbeing. In this case, you and your resident may well be right that no matter what you did to accommodate the husband, nothing would placate him. On the other hand, I have witnessed seemingly small gestures defuse seemingly irrevocably hostile situations. Time would have been expended rewriting the scrips; time was expended dealing with an angry, disappointed family member. Was there a way to help the husband feel competent and valued? Perhaps not. Still, if possible, it sometimes is worth the effort.
Hi --, you describe a frustrating, yet interesting case. The splitting of the husband and wife, with the husband embodying all the aggressive demandingness and the pt being meek and grateful is an intriguing phenomenon. The pt feels too vulnerable to question anything, so the family member takes on the role as defender, fighting all sorts of usually meaningless battles. It's too bad the husband left with such acrimony; and perhaps as you say there was no way this could have been avoided. Yet I can't help but wonder whether simply rewriting the scrips would have made this man feel competent and more in control. Hard to know. What's important is to think about the likely outcomes of our decisions and then choose whichever we feel best enhances pt health and wellbeing. I know I'm going to continue to ponder this situation!

To me, it was the right decision to address the issue head-on. I hope, without in any way excusing or ignoring his behavior, there was some attention to how frightened and hopeless he must have felt about his impending fate. It is obviously right that he be punished appropriately for his wrongdoing. Yet it is the responsibility of the medical team to prepare him in the best way possible to deal with his future life. Perhaps X felt too despairing, too much self-loathing, too much hopelessness to respond to the compassion and caring the team extended. One might argue that, because of his life choices, he deserved this suffering. Personally, without in any way excusing or ignoring terrible wrongs he committed, I believe that the obligation of the medical team would be to try to prepare X in the best way possible for the difficult life that awaited him. If the team did this in a merciful and nonjudgmental way, then perhaps X was simply not ready to receive this message. There is some small consolation in knowing that you all made the effort.
--, as you rightly noted, this was not a story of uplift. It took two disheartening turns. The first was when you learned that your lovely pt and girlfriend were really pimp

and prostitute; and the second was when X could not be persuaded back into therapy and was discharged to jail. I think what makes this story so tragic is its legacy of so many ruined lives: the women and girls whom X exploited; and his own life as well. It is easy to judge, and clearly X made some terrible choices in his life that gravely harmed vulnerable others; but the goal of the medical team was to prepare X as much as possible for the difficult life ahead. If the team made a good faith effort to convince X that his life was not over, that there was still some hope, then you did what you could. This is a situation where motivational interviewing might have helped move X forward; but it is also quite possible that he was not at that point of readiness to help himself. Hopefully he will get a second chance.

Despite your lack of success, in my mind you and your team were proceeding correctly. You cannot begin to solve the problem until you know what the problem is. You've figured out what is wrong and you're treating him appropriately. Why is he so upset?
This is obviously a very destructive and dysfunctional pattern of behavior. It is still incompletely explained. Why does he seek treatment only to leave AMA? It's too bad there was no opportunity to ask him to help you understand this behavior. What was he looking for and what was he not getting from all these different doctors and hospitals?
--, I hear your frustration and helplessness regarding this patient - and no wonder. He almost deserves a kind of grudging respect for his absolute refusal to let any of his doctors help him. Wow, is he stubborn! I have great admiration for your unwillingness to "let go" of this patient, and for being willing to stay the course no matter what he dished out. You persisted in asking exactly the right questions to try to get to the root of his anger. Until you understand that, you cannot begin to address it. Your thought of involving psych is a good one - his behavior may well be beyond mere noncompliance, and may be due to some mental disturbance. He may also simply be terrified of his serious medical conditions, fear the end of life, and be feeling terribly out of control. In any case, he needs a doctor who was willing to go above and beyond to try to reach him. You were ready to be that doctor. I'm sorry he didn't give you more of a chance.

--, I'm extremely impressed with your essay. I could not improve on your approach to this patient. You did so many things right: 1) You asked what is the problem - a thoughtful question that helps you identify your goals 2) You actively engaged the patient as part of the team 3) You offered positive reinforcement for cooperative behavior 4) You learned to respond with care rather than reflexively react to provocative or frustrating behavior. It's wonderful how well you've incorporated these fundamental principles of dealing with difficult interactions into patient care. I think the proof is in the final hug you received - your and the team's efforts transformed a difficult encounter into excellent patient care. You should feel very proud of how you all worked with this patient - and yourselves!

--, this was a heartwarming essay to read, and I really commend you for being willing to pursue the discrepancy between the pt's story and the imaging results, rather than dismissing the pt's subjective perception summarily. Your actions showed respect for your pt which, given her psych history, I'm sure she especially appreciated. It's a truism, but you really can learn a lot by listening to your pt.

True, you could not change her beliefs (she might have needed a psychiatrist for that!), but with patience and encouragement, you did change her behavior. You might have been frustrated that this patient utilized so many resources to make what was really an uneventful recovery; but on the other hand, I can envision this situation having turned out much worse (lawsuits, AMA etc.) without this judicious approach. The team did the right thing, and it resulted in the best outcome possible under the circumstances.
--, thank you for describing this interesting - and exasperating - patient encounter. While it is true that you could reason her into perfect patienthood, I'm impressed at the way the team handled the situation. It would have been easy for this to degenerate into mutual blaming and dissatisfaction. Instead, the team worked with the patient to overcome her anxieties, fears (and perhaps secondary gain from her pain) to meet her discharge goals. Believe me, it could have been much worse. I'd put this one in the success column :-)

Very well said. Trying to understand is a very important act of empathy and softens our judgment (why are these people being so stubborn?!). Yet part of the humility of medicine is recognizing that we can never walk in their shoes. Even when we face similar circumstances, our experiences will be different. So respecting their struggle while trying to move in a direction that also respects the patient's wishes is the ideal double movement.
--, this is written with your usual sensitivity and insight. You are very perceptive in realizing that the family's grief and guilt factored in to their need to be in control of these final decisions. You also see with clarity that encouraging patients to complete advance directives WITH THEIR FAMILIES (so that the families understand their loved one's wishes); giving families a little time to come to terms with impending loss, and respecting their need to be involved are all important ways of making these necessarily fraught end of life scenarios a little less conflicted, giving family more time to be present with and grieve for their loved one.

I thought you did a wonderful job with a pt who obviously was in a lot of emotional distress over her multiple medical conditions. Your idea of giving her space to do some deep breathing was really creative and seemed quite successful. Your use of the term HIV, although distressing to the pt, seemed hard to anticipate. The pt herself seemed quite labile, and I'm not sure you could have headed off her swings between aggression and apology. In leaving to get back-up you were not giving up or abandoning your pt, but seeking another strategy that would enable you to take care of her. Your openness at the end of the encounter to accepting her apology and giving her a hug was very touching. I think this patient was testing you, and you refused to cut her loose, despite her difficult behavior. There was a cost to you, to be sure, but I think it possible in a continuity situation that you could make progress with this patient and put her care on a more stable footing.

Hmm. Of course it's hard to comment from afar, and from a place of ignorance of the medicine. Yet I can't help but feel that at least some of this feedback is the result of the hierarchical nature of the medical system. Perhaps it was threatening to have a 4th yr student speak out with confidence? Did this threaten the carefully crafted roles of attending, residents, and students? One can easily imagine an environment in which questions and concerns (whether pertinent or not) are welcomed for their

ability not only to teach the learner, but to make EVERYONE on the team think and rethink their initial assumptions.
I think it is always a good idea to learn as much as we can from others' feedback. Being gracious and professional in how we respond to criticism is a sign of maturity. However, it is also important to be able to reflect carefully on feedback, accept what seems to be true and instructive, and let other parts go that may be motivated by others' ego or defensiveness or other issues. Always a balance!
You are quite wise in realizing that "defending ourselves" even when this is justified rarely changes the other's perception. Thanking people for feedback, identifying what you can learn from it and acknowledging that graciously actually probably is more effective in shifting others' viewpoints. It is always valuable to see how we come across to others, even when this is at variance with our own self-perception. Then comes the hard work of discerning what is worth retaining from this feedback and what should be let go.
Dear --, I'm sorry to learn of this difficult experience on your away surgical rotation, especially since, as you say, it was kind of a mutual interview. I appreciate your honesty in sharing the resident's negative reaction to your persistence regarding the patient; as I shared in my comments, I am not at all convinced that the resident was correct and that you should have kept your mouth shut. In my view, you were advocating for your patient, and if done courteously and thoughtfully, this is never wrong. However, I respect very much the way you processed the feedback; avoided the natural defensive reaction, and tried to simply absorb the feedback graciously. It is always a good first step to hear the other person's point of view with appreciation and interest. This does not necessarily mean you have to agree entirely (or at all) but in my experience, there is usually something that can be learned from others' feedback. Perhaps in this case, there might have been ways of nuancing your concerns while still stepping forward on behalf of your patient. It is up to you to figure out what is worth considering and what should be let go.

--, I was impressed by the insight you had into this patient. The question to ask is always "Why?" What underlies the pt's behavior? What is driving her? Your hypotheses were both empathic and plausible. Like you, I was impressed with the team's skill in dealing with the pt's resistance and disruption. It takes both patience and self-control not to simply react to these treatment dislocations and setbacks. Yet, as you saw, in the end, a difficult situation was ameliorated as the pt felt seen and heard.

Very well said, --. What is the sub-text? "No one cares." If you think about this woman's life, probably there are very few people who do care about her. She longs for caring, but is skeptical that as an old heroin addict, anyone is going to give it to her. People do say ridiculous things in support of their feelings that are easily disputed - but this usually does not change their feeling, and in fact can reinforce it. I respect that you had the humility to apologize and offer reassurance that in fact the medical team did care and was committed to doing their best.
--, thanks for sharing this moment. We all have stories like this, when our pique or fatigue or disbelief causes us to blurt out something that does not serve to facilitate the interaction. I admire your willingness to apologize to the pt (her statement was indeed pretty silly, but as you realized, her underlying feeling was not). Your conclusion was exactly right- validating feelings and asking to understand more will often lead to a much more meaningful and productive interaction.

Omigosh, --, this is incredibly beautiful. I'm in awe that you were able to trust your human instincts so completely. First, you recognized that what X was looking for was not a medical explanation. What she needed in that moment was not some white coat towering over her and lecturing her about blood draws. What she did need was someone in a "servant posture" (kneeling - as in the sense of servant leadership), providing some human contact, and reassuring her that you were there to help. I don't know if you do this sort of thing often, but it was an amazing human-to-human act. I'm really impressed.
--, I don't mean to flatter you, but this is one of the most beautiful encounters I've ever heard about. I'm so impressed that you were able to exercise such profound emotional intelligence in this situation. I'm really glad you chose to write about it in this essay because it's the kind of moment that quickly disappears - it is not charted, it is often not shared with others, it is "insignificant." Yet to me it encapsulates what good doctoring is all about. You read your patient so well and understood that she was expressing a deep emotional need, not an informational need. By lowering yourself to her level (very symbolic), by taking her hand (human contact), and by addressing her need not to be abandoned, you calmed and reassured her and she was quickly able to apologize for her outburst and continue in the care of her mother.

This type of emotional perceptiveness and sensitivity is invaluable in medical practice - it is truly the art of medicine. And in this instance, you were Picasso :-).

I agree with you. Non- or limited English speaking pts are often less informed and have less understanding of their medical diagnosis, prognosis, and treatment options, which of course is very wrong. This is partly the result of inadequate translation, but also avoidance on the part of the medical team to make the extra to ensure the necessary level of communication.
I think it's great that the resident took time to develop a plan with you; and to review strategies for breaking bad news. Still, this is a big responsibility to put on a third year with no previous experience in having this difficult discussion. It would probably have been better if the resident or attending had accompanied you, partly for moral support and partly for guidance if the discussion took a complicated turn.
As you know, many cultures and individuals hold this belief. Ideally, it might have helped if you'd been able to discuss this situation with the wife and problem-solved how to approach it. This does not mean that you would have acceded to her wishes not to say anything to her husband, but that she herself would have had a better understanding and might have been enlisted to help approach the situation. Of course, this takes time and coordination, which are in short supply in the hospital.
Yes, this is a valid dimension of autonomy. Sometimes you can ask a patient, "How much do you want to know about your condition?" to get some guidance regarding whether the patient wants to cede some autonomy to a family member. There is really no way to protect the pt from knowing ANYTHING about his or her condition - but details (for example specifics of prognosis) may be referred to in more general terms if this is truly the pt's wish.
--, thank you for your honest grappling with a complex issue. You made several important points: One is the importance of ensuring that limited English speaking patients receive the same care (and information and understanding) as more fluent patients. Second is the importance of our not projecting our own values and expectations onto patients. Third is the value of ascertaining pt's wishes regarding knowledge about his/her condition. Fourth is to involve family whenever possible when breaking bad news, both to ascertain their desires and, if possible, to enlist them in the plan. Finally, you recognized the need to ask for help when you have reached the limits of your skill. To that I would only add, it is the responsibility of attendings and residents not to throw inexperienced 3rd years into the deep end without a life preserver (which in this case is their time and greater experience). I

appreciated that you were able to extract so many valuable insights from this encounter, and I admired your persistence in continuing to dialogue with the distraught wife. This shows your commitment to your patient's wellbeing in a very impressive way.

--, what an incredibly frustrating situation. In my read, everyone is trapped in an unproductive situation. The pt's life, personality, and perhaps psych issues have brought him to a point where the only way he knows to seek relief from his pain is from a bottle or from a hospital. Neither is going to meet his needs. The physicians are bound to treat him, but they cannot cure what really ails him. This is someone with few coping resources who needs significant support to treat his alcoholism, extinguish his smoking, and generally help him function in life - but these kinds of supports are not readily available especially to someone with zero resources. The result is that he will keep returning to the VA for answers it does not have. Very sad.

I agree with you that attentive listening and holding onto your center in interacting with such a troubled individual are your best chances of understanding him, and perhaps identifying more appropriate resources to address his real problems. Unless this happens, the dysfunctional pattern you witnessed will continue to repeat.

This is very wisely stated; and I can understand that it took a little time to formulate this lesson. It sounds as though in this situation, you became excessively focused on the attending, to the extent that you forgot to appreciate other learning opportunities and precious patient interactions. It is very easy for this to happen, but it is not foreordained. By stepping back (as you did after the rotation), you were able to see that you invested this attending with too much power over your experience.
Interesting comment. I agree this is always useful. For example, what made this attending so disengaged? Was he burned-out? Was he socially awkward? Did he despise medical students? Was he going through a difficult personal time? It might have been hard to discern answers to these questions, but when we understand someone's motivation, even if we don't agree with the behavior, it softens our attitude and tends to make us less passive aggressive :-)
--, thank you for such a thoughtful and honest essay. You actually learned a really powerful lesson that I suspect will stand you in good stead throughout your career.

And if you learned it a little later than you would have liked, it will come in handy next time around (and for sure there will be a next time!). I think one aspect of this is to beware of giving others too much influence over your life and your experience. One detached attending should not be allowed to ruin your day (or your rotation). Find your joy elsewhere. Reach out to the guy if you can; and if you can't, then work around. As you realized, you'll feel better if you don't succumb to his indifference. And as you did, realize what's truly important - your patients and your learning. That even a very bad attending really can't take away from you.

--, I was struck by your comment that, because of your good language skills, you often had to "pick up the fallen pieces." While it's great that you take the time and make the effort to do so, this is not how a healthcare system should function. As you note, every patient regardless of language ability or education (or race, class, gender, religion etc.) should have access to high quality care. Every pt should understand his/her medical condition; the procedure/treatment being recommended; the risks and benefits; the alternative approaches, including the risks of doing nothing - i.e., the elements of informed consent. Thank goodness that you were able to discover the pt's bewilderment and fear; thank goodness you had the courage to bring your concern's to the attending's attention; thank goodness the attending took these concerns seriously and took steps to remedy them. Regardless of language barriers, regardless of time pressures, the patient must always be the priority.

This is an excellent insight. Medicine always trains to "go to the superior," yet this is a more formal - and often more embarrassing and punitive - process than simply trying to work things out directly.
--, although I thought you handled this situation well throughout its various permutations, you make an excellent point about direct communication. The hospital hierarchy is so powerful that it is easy to always "go through channels," which can feel punitive to the target and is often not all that constructive. Simply talking to someone can be a much more effective way of instigating change. With both approaches, however, you were a tireless champion of your patient, and he was lucky to have you in his corner.

The unknown is very difficult for patients - and for physicians as well. In these situations, it is especially important that the doctors do not let their inability to provide answers lead to frustration with the patient who is responsible for their feelings of incompetence and helplessness.
Yes, it is incredibly frustrating when you are doing your best to help, yet are met with blame and mistrust rather than appreciation. Do you think this reaction in some patients might be a defense against their own loss of control and helplessness? When no one can explain what is happening, at least if you can blame the doctors you have an answer (no matter how wrong).
Dear --, I loved the arc of this story. You started off, understandably, being frustrated and exasperated with this patient. You judged her as demanding and entitled (and I'm sure she was - that may have been her personality; it may also have been her way of coping with her own helplessness and loss of control). But then you recognized the parallels between the pt and yourself - both of you caught between constantly changing explanations and treatment plans. You were livid, and you understood her anger. You were tired, and you understood her (emotional) exhaustion. I think this realization actually made you a better pt advocate, although perhaps an annoyance to the multiple teams because you started to question them and try to get them on the same page. In my view, your efforts to address the lack of inter-team communication and coordination was necessary and admirable. I'm just sorry no one else was trying to solve this critical problem. If it had been addressed, I suspect this patient would have been more trusting, more appreciative instead of threatening to sue our hospital.

--, this is both a good insight and also rather hard on yourself. I suspect that, despite your apparent “failure,” you were instrumental in laying the groundwork for her eventual decision. It’s kind of like quitting smoking – a hard decision sometimes takes several times. I doubt your pt. would have listened quite so much to an ex-husband she hadn’t talked to in 10 yrs if you had not taken the time to explain so much and show a persistent interest in her wellbeing.

You are correct, --. Confidence is important - and this is true even when you don't know the answers, or when definitive answers unfortunately don't exist. Pts and family members will almost always respond positively to your confidence that you will do your utmost to track down available knowledge; and when you've reached the limits of what is knowable, that you will still do everything you can to ensure the pt's wellbeing.

Great lesson to remember. Although their frustration may SEEM to be about you, usually you are more the lightning rod. They can "order" you off the case, but they cannot "order" the clot to disappear, or the next PICC line placement to be successful. Being sick is a lot about loss of control, and pts and families can act in angry or hostile ways toward providers in unconscious efforts to regain some sense that their lives are not adrift.
Dear --, thank you for this very thoughtful essay. You realized that, often in such encounters, pt/family member hostility or pushback is not really about you, but about their fear and loss of control in scary circumstances. I thought what you wrote about confidence was very interesting, and it is worthwhile to consider that there are many kinds of confidence: a) knowing you can help a pt b) knowing you can find out how to help a pt c) knowing that you will always do your best for a pt and never abandon them etc. Confidence is not always about having all the answers (all that is great when possible) but knowing how to face NOT having all the answers. Patients need this kind of confidence too.

It doesn't sound as though you had any resources left to talk to anyone about anything! Which is completely understandable after enduring such an ordeal. Nevertheless, I think you are on the right track. The only way this resident will ever learn how much damage he's inflicting is through feedback. Under the right circumstances, this can be done professionally and in a non-attacking manner. But clearly you were not in a place to do this then. It is also possible to go to the clerkship director and provide input - not blaming or punitive, but informative. You do not have to fight all these battles alone.
--, this was an excellent and thoughtful essay about all you learned regarding the importance of personal wellness and the need to defend it if necessary. You also learned the importance of paying attention to more vulnerable members of the medical team, rather than exploiting their low status (as did your resident). People have to lead the way on wellness, because as you point out so well, it is not part of the historical medical culture. Only by looking for alternative ways of accomplishing caregiving goals can BOTH physicians and patients (and nurses and other staff) emerge healed rather than broken

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And this is even more distressing. It is understandably very hard for family members and patients to accept such difficult diagnoses (we call this denial, which sounds pretty close to patient blame to me). It is the responsibility of the physician to persist with kindness and compassion to help patient and family understand and begin to come to terms with what lies ahead. The problem is that often the physician him/herself is uncomfortable with this process and is not able to be gently persistent. Having once explained "the facts," the physician may feel the task is done; whereas in fact is has barely begun.
--, thanks for documenting a too-common problem in medicine; i.e., that the pt and family reach the end of life without truly understanding that this is where they are. Patients and family understandably can have a hard time accepting this truth; it is the responsibility of their medical team to make sure that they understand the realities of their situation. This is difficult to convey with the right balance of clarity and kindness; but it is a lot less difficult than having to live it, which is what physicians should remember when they become impatient or frustrated in these circumstances. I'm very glad you and your team were able to help the husband develop an understanding of what medicine could and could not do for his wife.

--, this was a very sad situation. It is true that some patients are unreachable; and that some patients are simply not ready to be helped. I wonder if you felt you understood the reasons underlying the patient's hostility and suspicion. Was there a psych component? What made him see his physicians as the enemy? It is a frustrating and helpless feeling to think that there might have been "a way in" to earn the patient's trust and find common ground, but that it was undiscoverable. There is some consolation in knowing how hard the team tried, but it is the kind of outcome which can haunt your sleep. Did this patient really want to die, or could he not see beyond his need for drugs? Under such circumstances, we have to question how much autonomy the pt really has (although of course technically he is competent to make his own decisions).

Such a great lesson. As the Cleveland Clinic Empathy video shows us, everyone is carrying around joys and sorrows, stresses and burdens that are invisible to others. If we extend a little patience and compassion, and give others the benefit of the doubt, we can usually build better relationships which benefit both patients and team.

Ah, I love this. Forgiveness is essential in medicine - not simplistic forgiveness, but forgiveness that comes after learning all that one can from a situation (as you did). Also, it can be hard to extend forgiveness to others but even harder, yet equally important, to extend it to yourself.
Dear --, great essay. I admired the way you refused to passively accept this frustrating situation and instead took action. What I particularly appreciated is that you did not start with complaint or attack (although these remained options if your kinder, gentler approach was unproductive), but instead tried to learn more about your intern and encounter him on a human level. Well done! I also valued what you wrote about patience and forgiveness. These are essential qualities in a good clinician, and I'm impressed that you are dedicated to incorporating them into who you are as a doctor - and perhaps as a person.

This is a really excellent analysis, --. "Different wavelengths" is exactly at the root of much pt/family/dr disagreements. Usually the pt and family are in no condition to untangle the mess - it falls on the doctor to sort things out. You demonstrated beautifully that this takes some time, but is very worthwhile indeed - for both family and physician.

Good for you, --. It would have been easy to confine your communication to the hearing friend. Yet, just because this individual is well-intentioned, and just because the pt agreed to have the friend involved does not mean that he can speak for the patient or make decisions on his behalf without pt input.
Dear --, thank you for getting in this essay. There were many challenging aspects to this case - the pt's lack of resources; the pt's deafness; the frustration of his friend; and the limited resources available to address the pt's underlying problems. I think you did an excellent job of keeping the pt in the communication loop, despite his deafness. This was both respectful and ethically sound. You and the medical team also clearly did what you could for the pt in terms of marshaling available resources to assist him. Finally, it seems as though you spent considerable time explaining to the friend what was and was not possible. I think one of the frustrations of this situation was that there was nothing better to offer the pt than a new pair of crutches and shelter numbers. Clearly his need was greater, but could not easily be met. It must have been hard for everyone involved to see this - pt, pastor, medical team, and you yourself.

Nevertheless, it is important to do what you can in the moment, which you all did. Hopefully at some point we will be able to build a society which is able to better care for the least of its people.

Good awareness that your frustration with your pt was bleeding into both your personal life and your professional life. How can you "fix" this? One way is to terminate interaction with the patient, as you did; and this can be a good option, sometimes the only option. Are there other ways of calming your emotions?
This is a very humble and wise conclusion, --. It is easy - and natural - to become frustrated in such situations. One possible response that can help is curiosity (not objectified curiosity but compassionate curiosity): What is going on here that makes this patient need to be persuaded to take his meds every day? Is it dementia? A personality disorder? Is he feeling out of control of his health and this is his way of regaining control? Becoming interested in the problem sometimes helps give us a little distance while allowing us to remain connected to the patient.
--, you showed excellent self-awareness by realizing that your reaction to this patient was adversely affecting you personally and professionally. Awareness is the first step in any constructive change - and this awareness can be difficult because you have to acknowledge that you are struggling. So good for you. In this case, you chose to create actual physical distance from the patient. Sometimes this is the best option. It is also possible to take a metaphorical step back by becoming interested in the problem confronting you (much as you would with a medical problem): What is causing this patient to resist his meds each morning? What underlies his behavior? By being curious (in a kind, empathic way) you can remain connected to the patient without paying such a high cost.

--, I have enormous respect for your ability to rise above this racist comment. Each situation is different, so there is no one correct way to respond. And I also agree that you can always learn something, and that once we hear someone else's story, they become more human. On the other hand, the casual racism that permeates much of our society should not be seen as being given an institutional "pass." Health care professionals have different views on how to respond; most like you consult the better angels of their nature and carry on with treating their patient. At the same time, it is also fair to consider the rights of nurses, orderlies, and housekeepers, as well as

physicians, not to be abused by racist patients. In any case, I loved your painting analogy. People are complex, and understanding them is indeed similar to creating a work of art.

You've said this beautifully --, I cannot improve on it. "There is always more to the story," as you say; and if you can become interested in this "more" you can accomplish much of what you want as a physician in terms of gaining pt's trust and cooperation.
Hi --, you demonstrated great skill - and great compassion - in not being put off by the pt's initial irascible behavior, but instead determining to "de-escalate." By listening for the root of his frustration, by empathizing with his truly tragic situation, in a surprisingly short amount of time you won him over and set him on a path of cooperation, patience, and gratitude. Those 10 minutes saved hours, perhaps days of mutually upset and angry feelings for pt and doctors and nurses; overcame resistance which would have resulted in compromised treatment goals; and created teamwork between pt and medical team. I'd say well worth it. Congratulations on your ability to deal so competently and so humanistically with this initially challenging situation.

I respect that you were able to reflect on not only what the patient might be bringing to this question, but what you were bringing as well. What you share makes a lot of sense to me. A tiny nation state, always under threat of being gobbled up by mainland China, needs people defending it. But as you've discovered, the majority of Americans can't even locate Taiwan on a map.
--, this is a very wise and perceptive statement. Family medicine does require building continuity relationships; and divulging something about yourself is often a good way to earn trust and put the patient at ease. Such disclosures should always be aimed at establishing common ground, rather than creating divisiveness that may make the patient feel unsafe.
--, you used an uncomfortable question as an opportunity to examine both pts' motives and your own. I thought you did an admirable job of recognizing that the question "Where are you from?" may be a genuine attempt to make a connection. You also were impressively nondefensive in realizing that you brought to this question a need to defend and protect your heritage and culture when perhaps such defensiveness was not necessary.

Nevertheless, all of this being said, I still feel the question comes across to many as a micro-aggression that implicitly says, "Do you belong here? Because of your appearance, I'm not sure you do." This can be discomfiting and even threatening depending on the circumstances in which the question is asked. Thank you for writing about this issue so thoughtfully, I really appreciate hearing your perspective.

--, two things I particularly liked about your intervention is the way you personalized the interaction with the patient; and your honesty. Your use of colloquial language was great - medicalese sounds uncaring and remote. A human-to-human conversation builds trust, as you saw, and puts the patient at ease. Very well done. Never be afraid to let being a doctor be filtered through who you are as a person.