AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I worked as an emergency department scribe for a few years prior to medical school and during the MS1 and MS2 years. Many of the physicians at this middle-sized emergency department were older and had been practicing medicine for decades-many of them even prior to the existence of emergency medicine as a specialty. One doctor in particular was very conservative in thinking and would often make comments to patients that were racist and insulting. For example, when he encountered a patient who solely spoke Spanish, he would ask how many years they have been living in the United States and why they hadn't learned English in that amount of time. I would often apologize to patients after he had left the room as many of them were at a loss for words. Over the years, I struggled with the decision of whether I should speak up, but I knew that many people had done so in the past with no results.

During one patient encounter on my final shift as a scribe, we were seeing a Spanish-speaking mother and her baby who had a rash that she was concerned about. The physician went in and started off by asking for the mother's name and how long she had been in the United States as he normally did. He then proceeded to spend only a few seconds with the patient before deciding he had enough history/exam and he left. This bothered me and I brought up my concerns to the charge nurse who was very aware of the physician's behavior but said there wasn't much she could do.

At the conclusion of his shift I decided it was time to speak up and I told him that, even though he had been practicing medicine for decades, that was not an excuse to not have a heart during his interactions with patients. I don't think he really was fazed by my comments, but it felt good to say something at the time. After seeing the impact that his actions had on patients, I couldn't help but feel sorry for them and understand why many people would rather deal with their health issues on their own rather than go to see a doctor.

COMMENTS: Ouch, ouch, ouch. It is particularly horrible when physicians use their position of power to inflict racist, xenophobic, or misogynist comments on vulnerable patients. I wish it were just a generational issue that would eventually die out naturally, but we've all seen examples of young neo-Nazis and white nationalist parading through our streets.

The issue of speaking up is an interesting one, and there are many factors to be weighed. It is true that it likely will not change the individual, although enough pressure may cause that person to keep his/her racist thoughts to him/herself. However, it is also worthwhile to consider the positive impact that registering a protest, no matter how mild, may have on the person on the receiving end. Finally, it can be the case that when enough people register protest (nurses, colleagues, even lowly medical students), administration may be forced to take action.

Personally, I feel you did the right thing to speak up to this attending - and it took courage because, while you were not as vulnerable as a patient, you were in a subordinate position to him. While your comment may not have altered his behavior, it is also the case that someone for him he presumably

hoped to be a role model told him to his face that in fact he was just the opposite. Imagine what might happen if he received such feedback consistently. At the very least it might give him pause. And this in itself would be a good.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

It was the first day of my psychiatry rotation on 2 North. I was very excited and nervous about what it would be like on an inpatient psychiatry service. I soon met my first patient. He was a middle aged gentleman who jumped off a car parking garage a couple weeks ago. He was transferred from medicine after undergoing orthopedic surgery for multiple fractures. I was tasked with the goal of getting a full history about the incident and his past mental health. When I broached the reason why he was hospitalized, he downplayed the event and implied it was an accident. I brought up the suicide note found on the scene in his handwriting. He said he never saw the note so he could not confirm its existence. I attempted to ask about his high blood alcohol level at the hospital, but again he brushed it aside and said he was just a light social drinker. Previous mental health history was self reported as none. He explained that he was an extremely happy person with many friends, family, a trust fund, and multiple homes in different states. He occupied his time playing golf, skiing, and traveling the world. When I asked if there was anyone he wanted us to contact, like close friends or family, he immediately said no. Yes, he had tons of friends and family, but he was not close enough with anyone in particular to tell them about his situation. He did not want to worry his mother and felt that he could take care of this on his own. Although my questions seemed to irritate him, he also emphasized that he wanted his treatment team to spend a lot of time talking to him. Once he started talking, it was difficult to get a word in and he would often go on long tangents. The whole conversation felt like it was going in circles, he would not give me a straight answer to anything I asked while simultaneously over embellishing his life and trivializing what happened. Walking out of his room, I felt extremely frustrated and unsure of my capability to obtain a good history. The interesting aspect of psychiatry is the emphasis on behavior and exactly what the patient said, even if it does not add up or explain the whole story. The attending physician spoke with him and decided that the patient likely has narcissistic personality disorder. It was easier to talk with him knowing that the typical traits of exaggerated self-importance, need for admiration, and lack of empathy would dominate the conversation. I found that the best approach was to be a supportive listener. I let him talk, and then redirected the conversation to focus on the topics at hand. People with these traits seem very pompous and arrogant, but often there is severely low self esteem and depression underlying this outward portrayal. I discussed his goals and how we as the psychiatry team could help him reach them. I found that bringing up mental illness always had a negative reaction, so I focused on broad goals like health, happiness, and relationships. There was not a big aha moment when the patient realized his behavior or admitted to feeling suicidal. I hope that he felt cared for and received the support that he needed in such a vulnerable time. I learned to be a more patient and empathetic provider and tailor my approach to best fit the patient.

COMMENTS: --, you have a great insight that knowing the psych diagnosis helped prepare you for certain aspects of the patient's communication that you initially found extremely frustrating. There is actually research that says when we attribute someone's challenging behavior as the result of illness or a medical condition that they can't control, we are more tolerant and accepting than if we feel it is something they are choosing to do.

I also admire the way you adapted your style of interviewing to the needs and limitations of the patient. Substituting terms such as health and happiness for mental illness seemed to help reassure the patient, although there was no big moment of breakthrough (and likely with NPD there will not be - it is more strategic chipping away at the narcissistic defenses, deciding when to "mirror" the patient and when to create a little discomfort by not reflecting their reality).

This patient has a long and difficult road ahead (as you note, severely low self-esteem and depression are actually hallmarks of NPD, especially as patients age and find themselves more and more isolated). You crossed paths with him briefly and during that time were able to overcome your own very understandable frustration with the patient, and instead did what you could to listen, support, show empathy and move him a degree or two closer to addressing his SA. You did exactly what was needed, and let's hope he will continue to receive ongoing intervention.

Art of Doctoring, Difficult Encounter, Assignment 1

I went to see a patient with a possible infection. He had multiple fluid loculations in his neck that were concerning for abscesses versus malignancy, one of which had grown to the size of a softball and was now diminishing with antibiotics. Neither cultures nor fine needle aspiration had revealed any clues as to what was going on. I did not have much time that morning because my other two patients required Spanish interpretation, so I was hoping to get the history from him quickly. I was relieved when I realized he spoke English. However, when I arrived he was on the phone with someone, in what appeared to be a slightly intense conversation. I waited in the doorway for him to end the call. Because I saw him look at me, I thought for sure he would quickly wrap up the phone call, given that I was wearing a white coat, a symbol of authority, and he was in the hospital, needing my help. However, he did not stop talking. Because of the intensity of the conversation, I didn't want to interrupt. Also, I was raised to be less pushy and more sensitive to people's boundaries, so the idea of interrupting anyone for anything is very taboo for me. But from experience, I also knew that if I waited too long to interrupt him, he could potentially sense weakness and walk all over me. I hoped that maybe he did not notice me, so I sat down in front of him, and waited a few more minutes. The phone call remained intense. It sounded like it was about his job. I began to get nervous, because I was going to run out of time. Frankly, I was annoyed that he didn't immediately end the call as soon as he saw me enter the room. What could be more important than his health at this point? Did he really need to continue his phone call or was he just being rude? "Sir, can I interrupt you?" I said. "No you may not!" the patient snapped at me. "It's my employer."

So I was right. Despite the patient's rudeness, part of me figured the humanistic, compassionate thing would be to let him figure out his work situation first. From the notes, I knew he was homeless, had poor dentition, and could probably use a job with some income. I understood it was possible his job was in jeopardy, as he had already been hospitalized for the past week and had missed a lot of work. I waited a few more minutes. As I waited, I imagined just leaving and telling my attending that he was unavailable to talk with me. The idea sounded absurd and dangerous. I imagined the shock on the fellow's face and my attending's annoyance and reprimands. I could let him continue. "Sir, I really need to talk to you. It's important for your health." The patient grumbled with annoyance. "Can I call you later?" He continued to talk. I wondered if perhaps he didn't know how crucial this time was for me. Perhaps he needed some education. "Ok... Oh, Ok ... Ok... Ok.... Bye," he said. "In the future," I said to him. "It's important you keep this time open in this morning. Doctors have limited time in the morning – ""I didn't call him. He called me!" the patient snapped. "I had to talk with him." "Oh, I see, it's unfortunate," I backed off, robotically trying the strategy of empathy. I was still annoyed with him. If he really had to talk to him, why was he able to hang up? "Is your job ok?" "I think so. I just needed to talk to him about hours." "I'm sure you're anxious to get out," I said, recalling the primary team's note about how anxious he was to leave. "I know you have been in the hospital a while. I just need to get a brief history from you..." Art of Doctoring, Difficult Encounter, Assignment 1 So, I was right. Despite the patient's rudeness, part of me figured the humanistic, compassionate thing would be to let him figure out his work situation first. From the notes, I knew he was homeless, had poor dentition, and could probably use a job with some income. I understood it was possible his job was in jeopardy, as he had

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rest of the interview went well. He warmed up to me. I sat next to him and listened to his heartbeat, listened to him breathe. It's a weirdly intimate doctors do with strangers. I stopped feeling annoyed at him, but I was glad I had asserted my boundaries. I saw him for the next couple days, putting on my nicest affect. None of his cultures grew and we never had any answers for him, but his grumpiness and anxiety faded. On my last day, I wished him luck with everything, adding that I hoped things go ok with his job. "Oh, that doesn't matter. I can stay here as long as you want." He stretched in his bed. "I'm retired." Retired? Then why was that phone call so important? I have no idea whether he was sugar-coating the fact that he lost his job, whether he was taking advantage of situation, or whether he just had no sense of proper organization of life priorities. He was, after all, undoctered and homeless, so there was likely a large component of psychosocial dysfunction. But regardless of what his story was, I realized there was more to it than I initially saw. What once had been a checkbox on my to do list, a faceless name in a chart with a complicated collection of fluid in his neck, was now a complicated human being living in a complicated world. And while I had only visited his complicated life for a few days, I had been forced to balance humanism with work efficiency. Somehow I had survived. I learned to assert myself, putting up my boundaries like a shield, while at the same time establishing a connection.

COMMENTS: --, I really enjoyed your essay. You tell a great story! I was so caught up in it that when I reached the information that this patient was retired, I too said, "What?!" Also loved your conclusion about "a complicated human being living in a complicated world." Very well put. Finally, I thought the lessons you learned were perfectly tailored to the event: 1) You survived, always important 2) you saw how to balance compassion with your own priorities (which actually were ones that advanced the best interest of the patient) 3) you were able to practice assertive skills while not cutting off from the patient and indeed building a connection.

It is true that, when we decide on a course of action, we rarely know the full story. We must make the best choice with the information available. In the initial encounter, I thought you did an excellent job of imagining the importance of work or potential work to this homeless patient and giving him some leeway in concluding his call. You also respected your own patient care obligations and

eventually intervened to refocus him on the medical encounter. This is the balance you noted, and to my mind, you did it well.

As a genetically "polite" person myself, I also admired your ability to be assertive with the patient without being aggressive. This is an important skill. There are many limits you need to set in medicine, but it is usually possible to do so without escalating conflict or being mean, so long as we remain centered and in touch with a certain humanistic concern for the patient, even as we must say no or require a certain behavior. You demonstrated the capacity to put forth your own needs (which in this case aligned with the patient's medical needs), but did so without any unnecessary judgment or harshness. The result was that you were able to have a relationship of trust with your patient and to provide the best care you could.

In the end, as you say, the phone call remains mysterious. Maybe it had nothing to do with a job. Maybe he was delusional. Maybe it was a power struggle with you as an authority figure. The key I think is that you were able to resolve the situation in a way that was respectful to the patient, to you, and to your other waiting patients. Well done!

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

When I was on my EM rotation at UCI, we had a patient in her 40's who had a recent "psychotic" break. She had become delusional and extremely paranoid over the course of 1 week but had no prior psych history or medical conditions. Her family was perplexed as she had also not undergone any recent trauma or loss. In the ED, labs and imaging were done to rule out medical causes. The last thing to evaluate for a medical cause was a lumbar puncture, but the patient refused. The question came into play, does this patient have capacity? On the one hand, should we not do the lumbar puncture when in actuality she had a medical root to her new behavior, we would be condemning her to a life of psychiatric medications and appointments. On the other hand, she was very nervous about the procedure and we would be forced to sedate or hold her down against her will. We decided to refer to the husband as the surrogate decision maker. He hesitantly consented to the procedure against her wishes after much consideration and deliberation, but then left for the night. We informed her of this decision, and she continued to refuse the procedure. Ultimately, we did not do the lumbar puncture

.This was an interesting case because we ended up going with patient's wishes rather than her surrogate, even though we were using a surrogate because we thought the patient might not have capacity. We could have done the lumbar puncture as the consent was signed, but somewhere in the decision process, the physician decided he did not want to force the patient to do a procedure she was adamantly against. Did we miss something by not doing the LP? Surely, the physician must not have thought the LP would reveal much... This was a case where judgement outweighed protocol, and empathy and compassion altered diagnostic studies and thus possible treatment plans. Clearly, intuition came into play exemplifying the art of doctoring.

COMMENTS: This is an intriguing ethical dilemma. You identify the key factors necessary to make a good call. 1) How useful would a further painful diagnostic procedure be in providing further information? 2) Did the patient lack capacity to consent or refuse the lumbar puncture?

As a non-physician, I have several questions. In terms of capacity, was psych consulted to determine capacity? Was the husband a legally designated surrogate? Who signed the consent form? And in terms of the lumbar puncture itself, what was the likelihood it could clarify the diagnosis? I was interested in the attending's decision NOT to proceed. This suggests to me that he judged his patient to still have capacity; and the procedure to be of limited diagnostic value in this case.

Physicians try to persuade patients all the time to do things they don't want to for their benefit. But persuading and forcing are two very different things, and a good doctor will only resort to "force," (i.e., overriding the patient's choice) in limited circumstances (insufficient capacity, child patient etc.) under very limited conditions. On the other hand, you always want to make sure that "compassion" for the patient does not move you in a direction that goes against the patient's best interests (let's forget about those insulin injections since the patient really hates the needle).

In this case, I wonder whether a Psych consult re capacity and an ethics consult re performing the procedure might have added other valuable perspectives, Ultimately, however, the physician must take the action s/he thinks best honors the patient's wishes AND is in the patient's best interests. Certainly this involves judgment, intuition, even "art" based on experience and knowledge.

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ART OF DOCTORING 2019-20.ASSIGN 1 DIFFICULT ENCOUNTER

When I was a third year medical student, I was very much looking forward to my internal medicine rotation as that was my specialty of interest. Going into it, I did not fully understand what my role as a medical student would be on the team, but as learned from previous rotations, I expected that I would figure this out once I got started with the rotation.

Unfortunately, I soon learned that the senior resident that was on the team at the time was not going to help me adjust into my role. This particular resident was not approachable, had poor communication skills, and did not serve as a good team leader. While he acted as an appropriate doctor for his patients, he was very difficult to work with on a team. He did not include residents or students in making decisions about the patients they were following, which created for discoordination during rounds and poor communication on the team. This resident additionally had a very standoffish demeanor, which made it difficult to ask him questions or connect with him as a colleague. In the first week of my IM rotation, having this person lead the team as senior resident made my experience very confusing and frustrating, as I constantly questioned if I was doing things correctly and felt my educational experience was being compromised.

At first, I just tolerated this resident's behavior as I felt I did not have any other choice. After some time, however, I realized the negative impact that my interactions with him were having on not only my daily experiences within the hospital but also when I was home in the evenings, as I carried a lot of it out of the hospital with me. Because he was so difficult to approach with concerns, the other medical student on the team and I decided to call our clerkship coordinator for advice. She listened very carefully and offered to switch our teams if we so desired, but recommended some non-confrontational strategies to deal with our situation, reminding us that we are often going to find ourselves in situations like these in the professional setting and it is beneficial to learn how to deal with them rather than escape from them.

While I never felt comfortable in directly confronting this resident, I started proactively asking for feedback from him. At the end of each day, I would ask him if there was anything I could do better or differently as both a student on the team or as a caretaker for my patients. I began asking him more questions about medicine to ensure I was getting the teaching I expected while at the hospital. Opening up these lines of communication with him reassured me each day that I was doing things to the best of my ability and still getting the experience I wanted. It also forced us to talk to one another more, which eventually expanded

to include conversations about outside interests and life, making for a more fun team environment.

From this experience, I learned that I am most definitely going to have difficult interactions with colleagues, attendings, patients, and families, but it does not help anybody if I were to stay quiet about it and bottle up my feelings. The only person who gets negatively affected in such a situation is me, as the “offending” individual may not even be aware they are causing these emotions in me, as was the case in this situation. Thus, I think that opening up communication is the best way to handle these types of situations, specifically in a nonjudgmental, appropriate way. By doing so, I will improve both my own experience and potentially the care of a patient who may be affected by being treated by a team of doctors who have a bad dynamic. Going forward, I have always made it a point to ask for expectations from the beginning, and continue to proactively seek feedback and ways to improve.

COMMENT: This is a thoughtful and perceptive essay. You derived many important insights. In my view, your clerkship director gave you good advice -it is understandable to want to avoid confrontation (I am a great avoider myself!) but in the end no one learns anything and you suffer the consequences alone. As you astutely observe, sometimes the offending party does not even realize they are causing offense or hurt; and silence deprives them of the opportunity to grow and change their behavior.

There is a place for direct (yet always respectful) confrontation, and there is also a place for indirection. The poet Emily Dickinson once wrote, "Tell all the truth but tell it slant." To me, this means that you always have to pursue the truth (in this case, the resident's poor communication, lack of inclusiveness, and inadequate leadership skills), but sometimes you can do so in a more roundabout way. You chose not to directly confront the resident (which may have produced only defensiveness and retaliation), but instead chose to stay present and gently persistent. You played to his strengths (his medical knowledge), while in essence "befriending" him, so that he felt safe enough to open up a bit, thus creating a more functional team environment.

Was this your job? No, it was his job. But he couldn't do it, so you stepped up and, for a while, did all the work. That wasn't fair, but in the end everyone benefitted - you because you felt you were not passive and victimized but rather were getting a reasonable educational experience; the resident, because he learned something about what it takes to lead a team; and the other team members, because they were now part of a team that worked. Communication is the foundation for everything interpersonal, taking care of patients, working as a team. You empowered yourself by taking responsibility to address the problem and in doing so gave everyone else a real gift.

ART OF DOCTORING 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

I met X in the pediatric ICU at CHOC. He was in diabetic ketoacidosis (DKA). During my short month-long rotation he was already the fourth “DKA’er” I had met.

X did not look like the others, however. Instead of the scrawny, cachectic child I had previously seen, he was impressively obese. His dad helped me get a history while his grandmother sat by the bed holding his hand while he slept. X’s father explained to me that one month ago, X had set out on an ambitious lifestyle intervention. He was eating healthier and exercising every day. In the week prior to his admission, however, he started to feel nauseous and no longer wanted to eat. He became increasingly thirsty and started to drink multiple 32-ounce Gatorade bottles every day. Eventually, he went to his PCP, who checked his blood sugar and sent him to the ER.

I asked about X’s family history. His dad explained there were type 2 diabetic grandparents on both sides of the family. “Any type 1 diabetes or autoimmune disease?”
“Lupus,” his dad said. “X’s mom passed away from lupus one month ago.” The air was sucked out of the room. I looked over at X, asleep with fluids and insulin pouring into his veins. His grandmother quietly cried while running her hands through X’s hair. “I am so so sorry,” I said. I stood there in silence, letting everything settle in my brain. It was hard to comprehend all of the suffering X and his family had gone through in 4 short weeks. I remember being so impressed by X’s father; he was so calm and collected. He kindly accepted my condolences and found a way to stay positive for X and the rest of the family. He told me that X’s mom was 28 years young. When asking about the rest of X’s medical history, his father replied, “Well his mom took him to most of his doctor’s appointments, so I can’t really answer that.” It Broke my heart. It turns out that X was trying to lose weight and get healthier in light of his mother’s passing. Instead, he ended up in the ICU with a new diabetes diagnosis.

Over the next few days, X recovered fantastically, as many DKA patients do. Over this time I got to know X and his family, and was amazed by the love and care that X received from aunts, uncles, cousins, grandparents, and his father. I was also impressed with X’s attitude. Only a a few days after leaving the ICU I found him in the playroom downstairs, making new friends and playing games. I was floored by his resilience and ability to smile again all in the wake of his mother’s passing and new diagnosis.
Though my encounter with X and his family was not challenging in the classic sense, that is, no voices were raised and there were no issues communicating. Rather, it was challenging for me to process the senseless suffering X and his

family went through in such a short amount of time. Having never personally experienced such an unexpected tragedy, I struggled to empathize. My natural reaction was to first imagine, how would I react were I in X's father's shoes? As a husband and a father, I am almost certain that I would not be the same calm, grounding force.

Reflecting back, I have thought a lot about the role of a physician in these tense situations. First and foremost, our role is to diagnose and treat the underlying disease, which is fairly straight forward in the case of DKA. Secondly, we can educate and provide reassurance when appropriate. Again, with DKA, plenty of reassurance can be provided. There are millions of children with diabetes who learn to manage their disease and live healthy active lives. Lastly, I believe the physician can take part in the healing of the soul. It is so easy to get lost in the medicines, lab values, and consults, that we often fail to stop and ask the simple question: "What should I say to this child who just lost his mom and is in DKA?" In the end, there are no magic words to make the situation any less difficult. However, getting to know X and his family, openly acknowledging the challenges he was facing, and acknowledging to myself that I could not fully empathize were all a good start to the process. With time, as I got to know X, it became easier to take part in his emotional healing. By the end of our time together, I learned to face these difficult situations with openness, honesty, and curiosity. Thanks to him, I feel better prepared to meet these challenging patients in the future.

COMMENTS: Wow, --, this thoughtful, empathic essay blew me away, especially the line "the physician can take part in the healing of the soul." That is such a powerful concept, and you express it so humbly. Please don't ever lose the conviction that you indeed can contribute to healing patients' souls. It is a true thing, and I have seen it time and again through the ministrations of a caring physician.

I also respected that you allowed yourself to be moved by the tragedies that had befallen this family. You opened your heart to X's loss. You were not afraid to feel just a little bit of the pain he and his family were going through. And what you discovered was that you could survive those emotions; and hopefully X and his family together can survive their own grief. It is by "accompanying" each other that we find strength to go forward.

Finally, I appreciated your wrestling with the issue of undeserved, innocent suffering. This kid and his family were undergoing unimaginable loss, and then were hit with the diagnosis of a chronic disease. Some things, in my view, are truly beyond our understanding. There is no way to explain this to patients or to educate them about why this has occurred. However, as you did so beautifully, you can stand in solidarity with your patients and families in the face of their suffering. As you did, you can acknowledge their courage and your humility in the face of that courage. You can bring qualities of openness, empathy, and curiosity to each encounter. In your interactions with this kid and his family,

you recognized both their and your humanity, and this made you a physician worthy of trust. You truly were this child's physician

CHINH TRAN ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

COMMENTS; During one of my overnight emergency department shifts, a very vocal and combative patient came in as a trauma. She was a young female in her twenties or thirties and was the drunk driver in a motor vehicle accident. The patient had a large, deep actively bleeding laceration to her forehead and was still intoxicated. She threatened multiple staff members, including the nurses trying to place IVs and the trauma and emergency medicine team trying to conduct her primary survey. The patient tried to refuse all care, threatened to sue the hospital, and said that her uncle "Vladimir Putin will come after you". Needless to say, this patient was difficult for the whole team to manage medically and empathetically. I closely observed the attendings' interactions with the patient. The trauma attending spoke to her very bluntly and told her that she lost all of her rights and privileges once she got behind the wheel drunk. Initially, the emergency medicine resident planned to sedate the patient with haloperidol, but the emergency medicine attending made the decision to intubate the patient after a few minutes of her screaming at the staff. I, as well as the resident, were both shocked about how quickly the decision was made to intubate. Given the chaotic situation though, I decided to wait until later to talk to the resident about the case. From this difficult patient encounter, I re-learned the lesson that many residents and attendings have told me over the past year: "There are multiple ways to skin a cat". Although I personally felt that intubation so early on was overly drastic, I also had to realize that the patience level of the providers was worn down and they would have been unable to get her to the CT scanner as quickly without intubation. I also learned the importance of having mentors and colleagues in the medical field that you can discuss difficult cases with. A few days later, I was talking with an anesthesiologist and discussed the case with her because it still bothered me at the back of my mind not knowing what the "right" thing to do was. She told me that her viewpoint was that agitation is not an indication for intubation or extubation. Although I am still very uncomfortable with the "grey areas" of medicine, I hope that being able to talk through difficult encounters will better help me establish my clinical judgement and ideals and values as a future physician.

COMMENTS: Dear --, perhaps as a non-physician I'm misinterpreting this scenario, but I wasn't clear whether this patient was intubated for medical reasons or to shut her up. The best I can undertand is that her behavior was out of control and made it difficult to care for her adequately.

To me, the questions would be 1) How urgent is the situation? I time is of the essence then the niceties of the patient-doctor relationship have to be set aside to aid the patient. 2) Is the physician making a decision based on medical necessity or on personal annoyance? In this case I was not sure, and maybe some of both. As a corollary to that question, a follow-up to ask oneself is,given how frustrated I am, is it in the best interest of the patient to intubate her so I can carry on with my task?

I'm so glad you were able to process this situation with the resident and anesthesiologist. Often in medicine, despite how you are trained, there is no clear-cut single right answer. Checking in with a colleague helps you see other perspectives or may help validate your choice, but in both instances you've taken a brief pause to ensure you are making the best possible decision. You want to be honest about your own limits ("I'm so aggravated by this patient I need to control her agitation to

care for her") and always question whether, with a little more empathy, you might be able to calm the patient in a less invasive way.

Drunk driving is a particularly triggering issue for many of us, and especially for ER physicians who see terrible results of drunk-driving related MVAs. I don't know if in this case others were injured or killed, but it is so easy to punish the drunk driver (and punishment does await this person but not from the doctor). Personally, I found the statement that "she lost her rights and privileges" an escalation of the situation, and likely to increase rather than decrease the patient's wild behavior. I'm not saying all of us don't have plenty of angry feelings in this situation, and this patient deserves whatever consequences come her way; still, it's important to remember that the doctor is not judge and jury, but healer. We rarely know the whole story, what led to this drunken rampage. A kinder attending, while in no way sanctioning the driver's actions might have been able to restore control without resorting to intubation.

ART OF DOCTORING ASSIGN 1 DIFFICULT ENCOUNTER

I once had a patient on my medicine sub-I who I never expected would turn out to be a difficult encounter. She was being treated for herpes zoster ophthalmicus (i.e.zoster of ophthalmic nerve(CNV1)dermatome)and needed IV acyclovir
.
Her diagnosis and treatment were straightforward, and she did not have any corneal involvement. After a day or two of treatment it was clear that her zoster was improving and she was being prepared for discharge.

It was the end of a long day and I was looking forward to heading home after discharging this patient. However when I explained that she would need home care to continue the IV acyclovir at home, she adamantly refused. I explained that the treatment was necessary to prevent the zoster from worsening and possibly affecting her vision. She then stated that no one explained to her that that was a possible complication (even though I had) and that she therefore would not agree to home care. She also said that she expected to go home and resume her normal activity, not continue IV treatment
.
She was upset and teary. I was perplexed by what appeared to be completely irrational thinking. I was also tired from a long day and I elt angry that I would have to spend the next however many hours trying to convince this patient to care about her own eyesight.

As I reiterated that going home with home care for the IV treatment was clearly the best way forward, I sounded like I was speaking to a child rather than a middle aged mother. I stepped out confused at the fact that such a straightforward dispo was such an emotional issue for the patient.

However after a repeat discussion I found out from the patient's son that the patient's underlying concern was how much the home care was going to cost. She was upset because her family was already spending a lot of money on managing her multiple sclerosis
.
However she did not articulate that during our initial discussion; what came out of her mouth initially didn't make much sense because she was coping in that moment with the realization that the zoster treatment was going to be more costly than she had prepared for.It was only after the case manager got an exact cost figure that the patient agreed to leave the hospital.

This encounter was a reminder to me that in moments of distress, people don't often say what they mean, and fixating on the logic of what comes out of a

patient’s mouth in that moment may lead to miscommunication and lack of empathy

.

The emotional state is an opportunity for the provider to look more deeplyat what the patient needs. Conversely, my own emotional state can affect the way I interpret a patient’s expressions, and it is important to resist the temptation to condescend to or demonize patients because it may be a sign that Iam simply not understanding their true concerns.

COMMENTS: --, your conclusion is so wise and perceptive I don't need to say anything. But I will because I'm the professor and that's my job :-). All the thoughts I planned to express as I read your essay you've already summed up eloquently: under stress and in distress, patients cannot always lay out a logical argument. Often they are embarassed by sensitive issues, such as money, and do not want to address them directly. As you say so well, when you encounter "what appears to be completely irrational thinking," that should be a cue to want to learn more (not, as sometimes happens), to blame or dismiss the patient). Share your confusion. "I'm not sure I'm completely following. Help me understand what is making you feel so upset." When you can demonstrate positive regard and empathy for even the most difficult encounter, you stand the best chance of getting to the bottom of the problem, which is where you have to start if you want to solve it.

The other excellent point you make is that the patient and their fear or shame or anger are only half of the challenge. The other half is you, the physician. You may be exhausted, hungry, resentful, and not eager to spend time on a problem that should not exist. This is perfectly understandable. And sometimes, you simply don't have the resources to overcome your own depletion. When this is the case, you have to forgive yourself, eat a meal, get a good night's sleep, take a few breaths, and try again the next day. But sometimes, as you describe so movingly, you can dig deep, realize the patient is asking for help (even in an upsetting way), and that with a little extra effort, you can figure out the meaning behind the irrational behavior; and then begin to address it. By talking with the son, by seeking out the case manager, you proved yourself to be a compassionate and caring physician who was able to convine his patient to do what she needed to do to ensure a good outcome. Well done!

ART OF DOCTORING 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

During my rotation in the Emergency Room I had several difficult encounters with patients and their family members, many of whom were merely expressing their frustration with the system.

One patient in particular that stuck out to me was an elderly gentleman who while intoxicated had fallen and sustained several large lacerations to his forehead. I was not involved in his initial workup, but throughout my shift I heard his intermittent angry outbursts to other staff members regarding his care. One hour before getting off my attending asked me to go see the patient and repair the large wounds he sustained.

Upon walking in the room I saw the patient lying in bed in a c-collar with dried blood covering his face. He seemed very uninterested in me at first and it took some time to get him to respond. As I gathered my supplies and prepared what I needed, I calmly explained to the patient what would happen. Throughout this the patient grumbled about the care he had received thus far and just wanted to be left alone. Prior to getting started I made sure to find the patient's nurse to make sure he received adequate pain medication since I knew this was going to be a painful procedure. His grumbling turned to yelling, profanities, and extreme irritability as I began to inject the lidocaine into his wounds so that they could be cleaned. Most of his yelling was about the pain of the injections and his wounds, but also how he felt that the people caring for him thus far didn't truly care about him. In response to this I remained calm throughout the process, not replying to his anger with anger, and empathizing with the patient about his pain.

Soon after I began the nurse arrived to give his medication, and the Lidocaine in the wounds began to work. He progressively became less angry and frustrated, and was pleasantly surprised about how effectively the lidocaine worked. As I continued to suture I emphasized that those working here were just trying to help, but also how frustrating the process can be, which the patient began to respond to much more positively. Since I was there for some time we began to chat about his life, and I learned that he was previously a teacher and passionate about history. Also sadly learned that his wife of 30 years passed away 5 years ago and since then his life had taken a dramatic turn. But he always came back to his love for teaching and how he stayed in contact with his students to this day, and I even learned of his family history in all of our talks. I shared with him things about my family and life, and over the course of 20 sutures we developed quite a banter. As I wrapped up the last bit of suturing the patient apologized for yelling earlier, and thanked me for my patience and the care I provided.
Through this experience I learned that staying calm in the face of difficult encounters with patients and empathizing with their struggles can help move a

difficult encounter to a positive one. I also saw how pain can dramatically change a patient and their interactions with providers. In this patient there was a significant change in his behavior after his pain was adequately treated, and I have continued to apply this lesson to future encounters. This experience ending up being extremely impactful in the bond that I eventually made with the patient, and taught me not to let first impressions guide the rest of an encounter.

COMMENTS: Many things impressed me about this encounter. First was your capacity to just "stay present" with the patient, even when he was yelling at you. We all have an impulse to reflexively REACT, mirroring anger with anger or defensiveness. But with practice, we can be more thoughtful in how we RESPOND, choosing calmness, compassion, and empathy even in the most trying circumstances. I really respect that you were able to do this.

Secondly, I was impressed that, given the tensions, you made the decision to get to know your patient over the course of the 20 sutures. While the lidocaine undoubtedly controlled his physical pain, your interest and attention I am sure soothed the emotional pain he felt - that no one cared about him, and perhaps even his grief at the loss of his wife. And not only did you get to know him, you allowed him to get to know you. Placing the sutures became not only a technical procedure, but a human-to-human encounter.

Finally, you are so right that pain can really bring out the worst in people. Effective pain management is a critical component of good patient care.

All in all, this interaction demonstrates your ownership of this patient, your patient-centered approach, and your finely honed art of doctoring skills. Nicely done!

DAVID JU ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

On a busy vascular surgery service, I was assigned to take care of Mr. J, a 66-year-old Taiwanese patient with limited English proficiency in the ICU. He had multiple significant cardiac co-morbidities and was on our service for bilateral above-the-knee amputations (both covered with dressings). He was kept NPO for a number of days before I saw him. I approached him at 5AM after reading his chart and recent vitals. He woke up without difficulty and acknowledged my presence with his eyes and a nod. After the usual medical student introduction, I listened to his heart and realized there was not much else I could do. For many vascular surgery patients, I would usually check the pedal pulses using the doppler machine but he no longer had any feet. I could not listen to his lungs because it was too difficult and painful for him to sit up in bed without creating a lot of friction to his dressing-covered bilateral amputation sites. The only thing he would ask me for every morning was a sip of water, with a please. After dropping by each morning for a few days, more or less to say hi, he asked me on the fourth morning while staring deep into my eyes. "Am I going to be okay?" he said. I stood there, frozen, thinking about my response options. All the words the managed to escape my mouth were "I...I don't know Mr. J." I could not lie and pretend that his condition was stable or reversable. I thought to myself throughout that day that I should have said more to make him feel more reassured. At 7PM that same day, his vitals suddenly became unstable and he took a turn for the worst. He coded for 45 minutes before ultimately passing away. All I could think about for the next few days, weeks, and now less frequent moments is that one question and his pleading request for some water. The dilemma I had with giving Mr. J false hope by lying to him versus being completely honest had me torn. Had I known that those few days were his last... I would have certainly given him more than a sip of water. In him, I saw the fragility of life. One moment, we were on the path towards aggressive surgery and recovery, and the next was his final words. At the end of the day, I wish I could have made his last few days in the ICU more pleasant... as one human to another

COMMENTS: I agree with --, this was a heartbreaking situation. And I hear your sense of guilt that, if you'd known your patient was dying, you'd "have given him more than just water." But I see your act a bit differently.

In the Gospel of Matthew, it says "I was thirsty and you gave me drink." One way to read this passage is that you address the need you see in front of you, what the other needs in that moment. That is exactly what you did. Beyond the literal sip of water, you gave the patient your attention (you noticed his need) and kindness (quenching thirst is a real gift). Sometimes simple acts of compassion have great value.

I also wanted to comment on your avoiding false hope and being honest about your uncertainty in responding to your patient's query. This was brave and, in my view, the best reply you could have given. It is facile but misleading to tell an extremely ill patient, sure, you're going to be fine. Many very sick people will sense the dishonesty because it contradicts their felt body experience. I think patients deserve the truth, if it is given to them with kindness and humbleness. It is not dishonest, however, to express your sincere desire that the patient will do well. That simply conveys that you, and the rest of the team, hope they will recover.

In short, I perceive that you acted in a very human way with this patient. Often, looking back, we feel that there is more we could have done. That may well be true. But that awareness should not negate all that we did do. Your patient was thirsty, and you gave him drink. That mattered.

AOD 2019.2020.ASSIGN 1 DIFFICULT ENCOUNTER

I walked over and introduced myself to Ms. W. She was lying on the gurney dressed in a patient robe in the pre-operative area waiting patiently to be rolled in for her 7:15AM scheduled surgery. Soon after my initial introduction, the attending surgeon and residents dropped by for any final questions and signatures. Before they could leave, Ms. W kept them captive with her detailed discussions about her secret chocolate making techniques and green thumb. As each individual peeled away as quickly and politely as they could, I sat close by waiting for the moment her gurney would wheel over to the operating room to begin her surgery. My one job that morning was to text the senior resident when the rolling process occurred.

At first, an hour passed and then shortly after...a few hours passed. As I sat there wondering what was going on, I got a call from my senior resident saying that an emergency surgery pushed our initial start time back by an unknown amount of time. Ms. W was very respectful and understood the situation. A few more hours passed and she continued to remain understanding
.
By around 3PM, the anesthesia team stopped by to discuss her past medical/surgical history and medications. For one reason or another, they determined that she was missing an aspect of her cardiology evaluation and decided that they no longer felt comfortable proceeding with her surgery at this time. In that exact moment, however, an operating room became available for Ms. W. She was feeling restless, hungry, and tired from waiting. Numerous discussions with the anesthesiology team took placeand ultimately a cardiology consult was ordered
.
Cardiology, however, requested another test, which would delay her operation until the following morning. After back-and-forth discussions, the attending surgeon was able to find an anesthesiologist willing to perform her surgery. It began at 6:30PM.

This encounter was difficult for many parties involved. I ran around all day looking for answers, from OR staff, the anesthesiology team, my senior resident and my attending surgeon. I did my best to keep Ms. W calm, distracted, and relaxed. After more than 10 starving hours however, with one unexpected obstacle after another, there was only so much talking and empathizing could do to keep a patient from feeling incredibly frustrated and upset
.
I can never predict how many challenges might come and I will not be able to control how others feel about each obstacle. I can however support each

individual emotionally in their experience by listening to them and empathizing with them.

COMMENT: The patient sounds heroic and you as well. 10 hours was an endurance test for both of you! I was not clear whether this was an entirely unavoidable chain of circumstances (certainly the emergency surgery could not have been avoided), or whether there could have been better coordination between anesthesiology and cardiology that could have facilitated a smoother process. Regardless, in the future, as you say, many difficult situations will arise that you cannot change. I agree completely that your task then is to support the patient by not abandoning them, by staying present, and by being emotionally available, all of which you did. This is a perfect instance of putting patient before self, which is necessary sometimes (although not all the time). I sincerely hope, after all that, that the patient's surgery was successful!

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

We had a patient on our thoracic surgery service that had undergone an esophagectomy, and two subsequent failed surgeries. He was severely nutritionally debilitated. He underwent a third surgery to replace his esophagus with his jejunum, which was successful. However, recovery was taking a long time. This patient would throw nurses out of his room, yell at residents that they were helping him, and tell our team that he wasn't updated on what was going on. I recognized that a lot of this frustration stemmed from seeing new faces every week, especially on a large team. Also, it was understandable that not being able to eat for an extended period of time was aggravating especially compounded with pain.I took the time to visit him and go over his list of questions. I was patient and took my time answering each one so he understood the plan of care and understood all the different teams that were rounding on him. Although he was still irritable, giving him some control of his hospital course calmed him down.In clinic for his first post-op visit, this patient was angry and threw his dad out of the room. When I asked him what medications he was on, he groaned and asked why it was important and that he had already told other people. I explained to him that I had to ask in order to make sure his pain was well controlled. When he understood why, he became slightly less irritable. To me, this patient had multiple very valid reasons to be frustrated and for lack of a better word, grumpy. I found it interesting that his mood affected every team taking care of him. People would avoid prolonged conversations in his room. It was very difficult for the team to spend extensive amounts of time with a seemingly ungrateful patient. I learned that it is important to continue to empathize with the patient's situation and try to keep that perspective in mind when offering care.

COMMENTS: --, many aspects of your essay interested me. First is the effort you made to understand where the patient was coming from. This did not excuse his behavior, but it made you realize that it might have been an expression of his fear, misery, and loss of control.

Second, I admired the steps you took to mitigate his "grumpiness." You answered all his questions and explained the plan of care. You helped him understand all the different specialists swirling around him. You showed him how your agenda (medication list) could actually help further his agenda (better pain control). All of these actions, as you insightfully point out, restored some control to the patient and helped him feel seen and heard.

Third, it is very much worth noting that the teams avoided this patient, didn't like conversing with him, and labeled him "ungrateful." You, on the other hand, were patient, listened carefully, and spent time empathizing with him. What interests me is WHY and HOW. Why were you able to stay present with this patient? How were you able to empathize?

The patient was not able to control his behavior, but you were able to control yours. I suspect your initial feelings were not all that different from those of the other professionals caring for this patient; but you were able to be the doctor you wanted to be with him. You've figured out how not to suppress your feelings, but rather how to recognize them yet not be run by them. This level of compassionate professionalism will stand you in very good stead next year and for the rest of your career in medicine.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

As a newly minted MS3 on my very first rotation, I had the distinct displeasure of working with a bad resident. To be fair, it was his first month on the job in a new hospital in a different state than where he trained. To be critical, his demeanor and treatment of patients was extremely concerning and directly led to poor outcomes on multiple occasions within a short time span. He routinely showed a distinct lack of empathy, and seemingly took pleasure in blaming patients for self-inflicting their ailments with their "non-compliance". He once ranted about a patient who claimed to be "allergic to morphine" and intentionally prescribed that patient morphine, precipitating an allergic reaction. He was remarkably out of touch with the idea of the therapeutic relationship. A young patient went so far as to leave the hospital against medical advice while in acute renal failure because he felt alone, afraid, and unsupported by his doctor. If these interactions sound horrifying, consider that these were only ones that I personally witnessed over the span of a few weeks. Amazingly, it is only with time and retrospection that I fully grasped how bad things were. As a result, things were left wholly unresolved between the resident and I.

While I was not able to do much more than provide anonymous feedback, I did learn immensely from reflecting on the situation. I was able to take away the following:

The patriarchal "doctor knows best" approach to medicine still exists and is practiced by young physicians to this day.

The hierarchical training system makes it difficult for students to provide real time feedback to their 'superiors', which can result in missed opportunities for learning and improvement in patient care.

I can indirectly offer feedback to residents by making non-judgmental observations about their interactions e.g. "that patient sounds frustrated that they're not being heard."

Patients can make harmful choices out of fear and desperation. If we do not provide them with a sense of safety, we cannot be effective in treating their medical problems.

Patients are vulnerable and often have no reasonable avenue of recourse if they are mistreated by a provider. In addition, most patients do not have a foundation of knowledge to even know when they are being mistreated.

When I am a resident, I want to create a collaborative learning environment where I can teach medical students as much as I can learn from them

COMMENTS: --, you recount a horrifying series of behaviors in this resident, and extract some extremely insightful and valuable lessons from these encounters. The question that springs to mind is how did this resident escape detection or consequences for his dangerous unprofessionalism? I suspect in part this was because, as you say, patients - and students - were too vulnerable to speak out; and superiors were too busy or too indifferent.

This may be a very burned-out resident who is externalizing his distress; or perhaps even someone with a personality disorder that makes him incapable of establishing therapeutic relationships. Or lots of things in between. The point is that the only way to put constraints on his destructive interactions with patients is to bring them to the attention of people who can impose some consequences on him, such as the clerkship director or the program director.

Frankly, it is not surprising to me that as a beginning third year student you had trouble initially interpreting the significance of the resident's behavior. Students are desperately trying to understand what "real" medicine is like, and if their first exposure is a terrible one, they may hesitate to label it as such without any basis for comparison. Even if you had directly confronted this resident, based on the behavior you describe, I think it is unlikely that he would have acknowledged his egregious errors and change his behaviors.

But finding some way to address the issue is important, because otherwise nothing will be any different for the next patient and the next student. In general, although I'm not sure it would have had an impact on this particular resident, I really liked your idea of "indirection" - rather than a direct frontal assault, to take a roundabout approach and see if the person gets the message. And again, if that isn't effective, bringing your concerns to someone higher up the food chain is an option, as you did through the anonymous feedback system. In taking any of these steps, it is important to remember that calling out bad behavior does not necessarily mean punitive consequences so much as getting someone help who desperately needs it.

ART OF DOCTORING 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

As a medical student, one often finds themself playing the “middleman” between patients and the rest of the care team. This role can be very challenging for many reasons. Firstly, the medical student is often tasked with relaying updates about the plan to the patient, and sometimes, the patient may not always be happy with the news. In a similar way, the medical student often helps with interdisciplinary communication, and can find him or herself caught in the crossfire between disagreeing teams.
In a recent instance, I helped care for a patient who, during the course of her hospitalization, became very unhappy with the quality of her care. The patient was admitted from the ED for pelvic mass invading her colon and ultimately required a colostomy. Because of the patient’s extensive disease and poor functional status, it was recommended that she be discharged to a SNF. This recommendation was very difficult for the patient to hear because prior to her cancer diagnosis, she was fully independent and active. Social work, physical therapy, case management, and the primary team all tried to speak with the patient empathetically about the recommendation for SNF placement. The patient continued to be in denial, and ultimately decided her case had been mismanaged and wanted to be transferred to another hospital.

As a medical student, I spent a lot of time speaking with the patient. I listened while she voiced her grievances, all the while knowing that her frustrations were more a product of her emotional turmoil than actual mismanagement of her case. I found it challenging to just listen rather than try to explain our reasoning and justify our actions. It was also challenging to communicate with other teams involved with her care—everyone was frustrated that they were being blamed by the patient, and in turn, people started getting

frustrated with each other. In this situation, I found it was best to just listen and empathize with each party involved rather than interjecting my own opinion that may fuel the fire. I learned a lot about the value of understanding different perspectives and realized that working together to come up with a solution is much more productive than trying to find someone to blame.

COMMENTS: In this excellent and insightful essay, we learn why we have the expression, "Don't shoot the messenger." You, the medical student, are not causal in any of these conflicts (patient-team, team-team) yet it is easy to get caught in the middle.

I appreciated several things about your reflection. First is your awareness that there are multiple perspectives and that sometimes there is no one "correct" way of understanding the situation. Helping people see things from others' perspectives can lessen heated feelings and pave the way for solutions.

Related to this is your awareness that seeking solutions is a better approach than placing blame. Pointing the finger may be momentarily gratifying, but it rarely leads to lasting resolution, and often alienates the very people who need to play a role in that resolution.

Practicing skills of listening and empathizing, as you did, can indeed be challenging. However, these are the best tools we have to communicate that we've heard and understood the other person. This sense of being seen and heard is fundamental to generating a plan and finding solutions to problems. It is how we create a sense of "we," all working together, rather than a bunch of "I's."

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

On my neurology rotation I saw the saddest patient encounters. Earlier in the week a younger gentleman presented to the emergency department with excessive vomiting and an inability to speak. He was also unable to move half of his body. I was on the stroke team at the time. A code stroke was called, and we rushed to the ED. After some investigation it seemed he had a stroke in his middle cerebral artery on the right side. His CBC was also was extremely abnormal with a hematocrit >60%, WBC >100,000, and his platelet count was higher than I had ever seen. He obviously had some type of hematologic disorder that he and his family was unaware of. After he was stabilized and brought to the floor, we learned he had a wife and a newborn child. He was still unable to talk but seemed he could communicate some things by writing. We though that the best treatment for him at the time was plasmapheresis to remove the excess cells from his blood. When we asked him if he would want to undergo the procedure, he continually wrote no. He would answer other questions with yes, but he seemed adamant about not undergoing the procedure. We were unsure he had the mental capacity to make decisions given his recent stroke. When we asked for him to explain the procedure and the risk of not undergoing to the procedure, he again wrote no. At this point we determined he did not have capacity to make decisions and asked his wife to make the decision for him. She was torn because he continually wrote no to undergoing the procedure. We implored her to agree to the plasmapheresis and after hours of tears and uncertainty on her part she said yes. He underwent the procedure and a few hours afterwards he had a huge subarachnoid hemorrhage. His pupils were dilated, and we believed the best thing to do at this time was to remove him from life support.

We don't know what caused the subarachnoid hemorrhage, but it seemed likely it was related to the plasmapheresis. Although the patient did not meet criteria to make decisions, I am still unsure whether he was able to understand what we were saying and really did not want to undergo the procedure. The conversation we had with his wife was also one of the most difficult. She believed her husband was able to make decisions for himself, but we convinced her that he had no idea what was going on. We were persistent and assured in the treatment we were offering, but obviously it didn't work. Telling his breastfeeding wife that she should let her husband die was one of the most awful moments I have had in medicine. I'm still unsure if we made the right decision or if we should have trusted the patient even though we believed he couldn't make decisions. Unfortunately, there is no resolution to this patient encounter, but I learned a lesson from this experience. We do not always know what's best for our patients and sometimes if people refuse treatment we shouldn't necessarily push back. People and their families have autonomy, and it's their decision to drive their healthcare and our job to guide them in these decisions.

COMMENTS: --, what a terribly painful experience. The tragedy for this patient and his young family is almost too much to imagine. The awareness on the part of the medical team that their treatment might have contributed to his death is also an incredibly distressing burden to bear. I appreciate your honesty on that point, as many would have shied away from facing the likelihood that medical intervention was a factor, maybe the significant factor, in his demise.

Other than the patient's dying, the extremely troubling - and as you say, unresolveable - aspect of this case is whether the patient had capacity to refuse treatment (as the wife believed) and was overridden by the medical team; or whether he did not understand the option offered and did not have capacity at that point to engage meaningfully in decision-making. Since he could only write yes or no, it seems impossible to determine the answer with any certainty. It also sounds quite uncertain whether, without intervention, he would have survived.

In the end, I think a case like this is all about forgiveness - in some form, asking forgiveness of the patient whose life you were not able to save; asking forgiveness of the wife and infant child who have suddenly lost their husband and father; and most importantly learning how to forgive yourself and the rest of the medical team for not being infallible and perfect; for making your best decisions that sometimes may not be good enough; and once in a while, for causing harm, irrevocable harm, despite having only the best of intentions. Think about writing a letter to patient or wife (not to send, just to write), and sharing what is in your heart. Being a good doctor means owning that you are not perfect, that once in a long while terrible things happen, while remembering that every day you do great good in the world. As you have done, learn what you can from the experience, ask forgiveness, and forgive yourself. You will never forget this patient, but you will not be chained to him either. He taught you the value of humility in medicine. Thank him.

AOD 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

Today, I had a patient encounter that left me with many emotions including frustration, anger, fear, hesitancy and self-doubt. To begin with, the patient presented with concern for J-Tube leak from his recent surgery. Though this began the circuitous conversation, his wife interjects his main concern is his hemorrhoids. I try to listen patiently, though it is immediately obvious that this will be a trying conversation. The patient speaks broken English with a heavy Philippine accent. I ask a question and he responds on a different topic with round-a-bout information. I ask “can you tell me about the hemorrhoids” and he yells “I poo poo when I pee pee! I poo poo when I pee pee!”.

At this point my attending turns to me and says “okay get the nurse and you’ll need to do a rectal exam. I’ll come back later”. I freeze. I have never done a rectal exam on a patient outside of my standardized patient in clinical foundations. I am now stammering on equal terms as my patient and try to get some more history. He has been wearing diapers. Why? “I poo poo when I pee pee”. I ask about urinary symptoms? He answers no everything is fine with that. I get more confused the more I ask. He describes hemorrhoids that look like a cauliflower and my understanding is external hemorrhoids.

I go find the male nurse to supervise the rectal exam. Somehow, I remember to wear gloves, get lubricant and explain the procedure to the patient. When he drops his pants I see no evidence of hemorrhoids. The cauliflower he describes is nowhere to be seen. I finish the rectal exam, collect my thoughts and go find my attending. I describe what to my inexperienced eyes and hands was a normal exam. When I give my assessment and plan I and frustrated on several levels. I was left in an extremely uncomfortable situation, fumbled through an exam and am worried my inexperienced care is inadequate. From a medical standpoint, there is not much to offer this man who I can only imagine is in serious pain to undergo a rectal exam by a green medical student.

In the end, we prescribed him a liquid stool softener that can be delivered through the J-tube. I spent a half an hour looking up dosaging and formulations (the pharmacy had no idea). I eventually got in contact with his surgeon who visited the ED. The patient was overjoyed to see her and discuss his treatment – he was nearly in tears. Though there was significant frustration on my end during the encounter, I feel this is the nature of American emergency departments. Patients with sub-par healthcare and complex medical conditions eventually boil over to the brink and end up in our doors. And when that happens, the 4th year medical student does a rectal exam.

Through this experience, I learned a few things. One, that I am happy I am not pursuing emergency medicine. I also learned that with difficult patients the key ingredient is patience and understanding. It was not this man's fault that he was in pain, or a poor historian, or demanding or had a chief complaint that necessitated a rectal exam. He badly needed care. I also learned that as an attending I will try to be empathetic towards my medical student's degree of comfort and avoid leaving a student in a similar situation without supervision. This is not only for the student's comfort, but also the patient's well-being.

COMMENTS: --, these were a lot of burdensome emotions to carry from this one encounter. I'm glad you had a chance to write about it.

There are so many problems to unpack: 1) The patient - and his wife 3) An attending who left you to do a sensitive procedure you were not practiced with 3) The significant shortcomings of the American medical system. None of these has a simple solution.

The patient (and wife) - as you say, not his fault he struggled to communicate and that he and his wife describe a hemorrhoid that is nowhere to be found. It is highly unnerving for the medical student (or physician) not to feel you have all the information or that it is uncertain or inaccurate. I respect that in that uncomfortable situation, you resisted the impulse to blame the patient, which would only make it harder to navigate. I did wonder whether the patient felt his agenda - understanding why he pooped when he peed - was ever satisfactorily answered.

The attending - I consider this the most upsetting aspect of this interaction. Of course, ED attendings are always juggling nmany different priorities - yet the medical student is a key priority as well. Here the attending had a responsibility to kindly and nonjudgmentally assess whether it was appropriate for you to do the rectal exam on your own. If this was not in the best interest of the patient (and as you empathically note, perhaps it was not), then s/he needed to stay and supervise.

Your comments about the many failings of the healthcare system (and not just in the ED) unfortunately are very well-taken, and beyond individuals to solve. However, we can all take whatever actions we can to support more equitable and just healthcare in this country; and, as you do commendably, not take the easy way out of blaming a patient who himself is really a victim of an inadequate and discriminatory system.

To my mind, there are two heroes here. One is the surgeon, who came to the ER. Just think for a moment how hard that is for a busy surgeon. And also see how much this visit turned things around for the patient. By being willing to interrupt his own to-do list for a few moments, this surgeon was able to reassure the patient and hopefully get his care back on track.

At the risk of embarrassing you, for me you are the other "hero." You did not do anything astonishingly heroic, but what you did do was hang in with the patient. You struggled through the language barriers, the unclear history, the back and forth with the wife, the insensitive attending, the

unfamiliar rectal - all to do the best you could by your patient. This is what will make you a great doctor.

ART OF DOCTORING ASSIGN 1.DIFFICULT ENCOUNTER

During my medicine rotation we were treating a patient for a true medical condition, but we could also tell he was pain medication seeking. It was hard to tell the difference between the pain medications he required and those that he was addicted to. He was constantly yelling while in his patient room causing a commotion in the tower third floor. We were giving him potent and appropriate pain medications, but nothing seemed to help this patient. On chart review, there appeared to be several other admissions where providers were facing the same issues. The patient then required a central line, and during the process, the resident blew threw the vein and caused even more pain for this patient, so at this point, it was becoming even more complex.
As a medical student, I spent all the extra time I had just checking in with the patient. I noticed he would be very quiet in his room until he saw a provider or nurse walking by, at which point he would scream for help and state that he is in 10/10 pain. As a team, my senior resident advised me to avoid excessive interactions as it will only make the matter worse. Instead, we approached him as an entire team and told him exactly what we are capable of doing and that we truly cared about his pain but we are not able to feed into his addiction. I learned that as providers we must finely balance what we learn in medical school and also during training, as well as what we are feeling.

COMMENTS: This sounds like a very difficult situation, --. It is often the case that patients are both/and - have true pain, and are also asking for inappropriate opioids. As of course you know, management is difficult, and not always effective because the need for drugs overrides the usual relational factors we rely on in challenging encounters.

Nevertheless, your team took exactly the right approach. To avoid splitting, the team needs to present a united front. Part of this united front is limit-setting: we are giving you appropriate medications to manage your pain. We cannot give you more medication or the medication you're asking for. Part of this front is, as you highlighted, expressions of genuine caring. Pain is a horrible thing to endure, and I am so sorry you are suffering. You can offer whatever pain managements are available, and beyond that not judge him for his misery.

Finally, it is hard to feel a patient is manipulating you - i.e., exaggerating pain when you are around, creating a scene in the hopes the team will cave just to quiet him. Once again, you can let him know you understand his situation, you are doing what you can, and his screaming will not change that. In fact, that level of agitation may exacerbate his pain. Recognizing that the patient's behavior is not personal (although it feels personal!), but is rather the inevitable byproduct of his addiction may help in maintaining firm boundaries within the context of genuine caring and concern.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

"My daughter's a neurosurgeon" – a phrase I'd become all too familiar with during my internal medicine rotation. One of my patients, an accomplished former white collar professional, would repeat it each day, partially because he was proud of his daughter's accomplishments but more so as a means to remind us that he would be getting a second opinion on each of our medical decisions. This immediately created a tense environment, one where it seemed as if patient and provider were at odds. This made it very difficult to establish the therapeutic alliance necessary for quality medical care, especially since I was fairly inexperienced in difficult patient encounters.

To counteract this growing sentiment, I tried to come up with different ideas to cut the tension. I offered to speak to his daughter; I printed out UpToDate patient information articles for his reading pleasure; I responded to each page within minutes to ensure all of his needs were met. But, frankly, his attitude only worsened. He began to refuse lab draws and scheduled medications, insisting that we "provide evidence" to convince him abide by our current medical plan. This was difficult to accept, especially because he had a slew of serious medical problems that we were trying to address. But one day, I took a step back and saw something new: the way he looked at my attending, a man forty years my elder, with such admiration and respect.

He didn't require "convincing" when this physician told him our plan.
That's when I realized that my age may have been a limiting factor. I finally started to understand why I had to "prove" my knowledge. I was neither a young,budding neurosurgeon or an established, seasoned internal medicine physician; my patient was skeptical that I, a 25-year-old, understood the finer aspects of medicine. To counteract this, I decided to talk more about the nuances of his medical problems and gave into his demands to explain each medical decision. Eventually, he let up and started to trust me and understood that our attending physician, the one he admired so much, was approving each of my decisions.

This situation taught me that in difficult patient encounters, it is vital to take a step back and try to see where the patient is coming from. My patient's unreasonable behavior was simply a manifestation of a legitimate and reasonable fear: his life was in the hands of unknown strangers. Once we addressed those fears and laid them to rest, we were able to form a stronger patient-provider bond and, ultimately, provide meaningful medical care.

COMMENTS: --, you have some really valuable insights in this essay. I'm particularly struck by your awareness that "unreasonable" patient behavior usually has an explanation; and until you know and

understand that explanation (which does not necessarily mean you agree with it), it is difficult to make any headway in treating the patient.

I think we agree that at the bottom of this patient's questioning and demand for facts and evidence was the issue of trust. He trusted his daughter; he trusted the experienced attending; and (unfairly) he didn't yet trust you. Once you figured this out, you had a good hint about how to win him over - by demonstrating your knowledge and expertise and by using the authority of your attending to reassure him about each decision.

This approach was based on your careful observation and reflection to analyse what might be causing the patient's behavior. Rather than be defensive, or attack the patient, you brought curiosity, compassion, and caring to the situation. As a result, you succeeded in building trust, establishing a real connection, with the result that the patient received the medical care he needed.

One other thought - once you uncover a root issue, consider raising it directly. In this case, you could acknowledge how scary it is to be hospitalized, how scary it is to have your life in the hands of people you don't really know. Then you can reassure him that you understand that, and that the team is working hard to ensure he gets the best possible care.

The key issue is to realize what is driving the patient's behavior and then see if you can address this concern. It isn't always possible, but knowing the larger context gives you a better chance of overcoming doubts and suspicions to enable you to do what you want to do - care for your patient.

AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

Recently on my emergency medicine Sub-I I was taking care of a young man with poorly controlled HIV. From his chart review I saw that he had moved to the area about a year ago and had been intermittently compliant with his anti-retrovirals, no-showing on several infectious disease appointments in the past few months. His chief complaint today was “diarrhea” so I entered the room with my usual high energy and began the encounter.

The patient was sleeping and I had to repeat his name several times to arouse him. He looked around grumpily and said, “Oh.’ When he looked at me. I went through the usual HPI questions but the patient seemed reluctant to answer many of my questions, saying, “I’ve already told other providers about this,” or “why does that matter, I’m here for something else.” At some point he told me that he did not want to talk to me, and when I asked why he said, “I don’t buy your peppy act’ (there was a little more colorful language in there, but I chose to omit it). I realized I was not going to make much headway with him so I asked, “What can we do for you today.” And he responded “I want to know my CD4 count and viral load.”I went back to my attending and presented as much information as I could and included the patient’s attitude. He suggested I come back to the room with him, and that possibly returning with a figure of authority would be helpful. He also added that not every patient will like you or want to work with you, and that’s OK. When we returned to the room the first thing the patient did was apologize for his behavior earlier, saying that he was in a bad mood and it was out of line. The rest of the encounter went smoothly and we were able to provide the patients with the services he needed.

It was a valuable experience overall. I got a better understanding of how to deal with a patient who is unwilling to talk with me and how to elicit information from a difficult patient.

I also had closure on the scenario with the patient spontaneously apologizing, though I know that will not always be the case.

COMMENTS: --, you did good work in difficult circumstances. In my view, one of the best questions you asked was "How can we help you today?" This puts the patient's agenda front and center. Although of course taking the HPI is essential, it can sometimes make a patient feel as though their reason for coming and their concerns are secondary. Your skillful question highlighted your willingness to highlight your patient's priorities.

I also have a thought regarding the comment about your "peppy act." Positive energy is always a plus in the patient encounter, and can bring hope and encouragement to patients, so good for you to somehow find the "high energy" encounter after encounter! Of course, it is also important to "read the room." If the patient is angry, sad, fearful etc., an excess of "peppiness" might at times seem inappropriate or even insensitive. Tailoring your emotion to that of the patient 's (e.g., anger in a

patient might elicit concern on your part) also lets the patient know that you are focused on them and their needs.

Finally, while I certainly agree with the atttending's comment that not every patient will like you or want to work with you, just because a patient is grumpy or rude does not justify immediately washing your hands of them (which you certainly did not). Instead, just as you did, the key is to "hang in" with the patient, seeking that way forward, in which you find common ground with the patient and the patient feels you are on their side (which you did superbly). When an encounter is unsuccessful (and of course this does happen), you want to feel you used all your skill to turn it around. Often all it takes is not escalating the conflict, not being defensive, and demonstrating sincere interest in and desire to help the patient. There is a reason he's sitting there in front of you! At least a part of him does want help, and your job is to do your best to figure out how to give it to him.

I'm glad this patient realized the error of his ways and had the grace to apologize. The goal, of course, is always to meet the patient's needs and, by addressing the interpersonal tensions well, you were able to do so. Nicely done!

AOD 2019-20 ASSIGN #1 DIFFICULT ENCOUNTER

While on my internal medicine rotation, I had a patient with a history of multiple old pulmonary emboli in her lungs and multiple old deep vein thrombi in her legs and in her abdomen who presented with severe abdominal pain, presumably secondary to the thrombi. We quickly sent labs to figure out what could be causing her emboli/thrombi and also gave the patient strong pain medications as well to make her comfortable. It was only later on while we were reviewing her chart that we found that she had given multiple contradicting answers in terms of her own medical history, her family history, and her social history (in terms of drug use) during previous office visits, and that there was also contradicting information in the records that we obtained from an outside ED. When we contacted the pain medicine service for assistance in managing her pain, they also felt that the patient had been giving contradictory information and was drug-seeking.

Thus, seeing as the patient was stable and could have outpatient work-up and management of heremboli/thrombi, our team made plans to discharge the patient. We did not prescribe the patient any opioids despite her requests and explained to her the risks of these medications. We told her that we wanted her to work with pain medicine outpatient in order to find a regimen that could be both safe and effective for her; however, the patient was unhappy with the outcome and continued to ask for opioid medications. She refused the walker that she had wanted earlier and left the hospital.

In future encounters with similar patients, I've thus learned that although our team tried to be empathetic and respectful while discussing the plan with the patient, perhaps a different approach might have helped reassure the patient. For example, motivational interviewing could have perhaps helped the patient come to a better understanding of the harms of consistent and unwarranted opioid use, and may have encouraged her to be more accepting of the non-opioid regimen and the plan for future management by pain medicine.

Comment: This essay considers an innovative use of motivational interviewing to deal with a patient looking for opioids. Although MI might not have quickly resolved the problem, such an approach could have provided valuable information about the patient's willingness to tackle her addiction. As you discovered to your chagrin, "telling" a patient about the dangers of opioids is rarely going to persuade a patient who is addicted to forgo them. It's a difficult situation. After consultation with pain management, you determined that you could not continue to prescribe these medications. This sounds like an appropriate limit, and the only way it can be softened is by offering alternatives for future management and building the patient's hope that solutions are possible. MI is an effective way of beginning a process that could empower the patient to address her own addiction. Sadly, it probably won't happen in a single hospitalization, but it might lay the groundwork.

AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTERAn 18-year-old female was admitted to medicine for an intentional overdose on bupropion. During initial interview, she disclosed that she had been repeatedly sexually assaulted as a minor by several extended family members. She did not want to give details but knew that it had also happened to her younger sister. She also made sure I knew that nobody else in her family knew and she did not want them to find out because it would negatively impact the positive relationships and family dynamics. On my way back to the resident workroom, I remembered that I was obligated to report this as she was a minor when it occurred and there are other minors still at risk. So I reported it to the local police who told me that someone would come to the hospital and speak with the patient. I knew there was a difficult discussion to have with the patient before police arrived to start asking her questions about an event she thought would be kept confidential. While interviewing pediatric populations, we are taught to inform the patient that "everything we talk about is confidential, unless someone is hurting you, you are going to hurt someone else or you are thinking about hurting yourself." Because she was already 18, I did not think to preface our conversation with such a statement. I did not even consider this until after I left her room. My dilemma was that I knew I would break her trust but was required by law to report this. When I returned to inform her, I did so as empathically as I knew how, although not apologetic. I could see the disappointment and anxiety in her face immediately. She said, "I thought you weren't going to tell anyone?!" then asked, "well what if I just lie about it?" I told her that it was her right to do so, but that there may still be other children or minors at risk. I tried to offer her the chance to be angry at me or ask questions, but she otherwise remained pretty quiet. I did not feel like she completely hated me at the end of our conversation, but I did feel like she will have difficulty trusting medical professionals because of our interaction. I still question whether it would have made any difference if I had turned around on my way to the workroom and had this discussion with her before I reported the incident.

COMMENTS: --, this was a tough one. I actually love the language you are trained to use in Peds - it is so simple and gentle and shows such concern. Of course, as you remembered, you are legally obligated to report such an event. So you had to go forward, and good for you for doing so, both in terms of reporting and in terms of informing the patient. That is really a good example of taking responsibility for your actions, and in this case, for this significant oversight.

The original problem was not qualifying the promise of confidentiality with the typical language. Once that had occurred, it doesn't seem to me it would have made much difference whether you told her you would need to report before or after you actually filed a report. Letting her know that you were obligated to report BEFORE reporting might have given her more of a feeling of being included, but it did not really restore a sense of control since she was no longer the decision-maker. In my mind, the most important thing is that you returned to the patient's bedside and owned the mistake as well as disclosing the consequences of that mistake. This is the sign of a moral physician - not never committing an error, but being able to acknowledge it.

Also, I'm going to have to challenge your conclusion that "she will have difficulty trusting medical professionals" in the future as a result of this event. I think that is possible. However, I also think it possible that she learned doctors are capable of error but also capable of apologizing and doing what

they can to make things right in a difficult situation. She may remember the breach of confidence but she may also remember your sharing both your action re the police as well as why you took it (the law, yes, but also to safeguard the remaining minors). In the end, she may come away with the feeling that doctors aren't perfect, but they are invested in protecting vulnerable patients.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

The first day I cared for Ms. X, she did remarkably well. She was recovering from a robotic risk-reducing surgery for a recently diagnosed BRCA1 mutation. She was meeting her post-operative milestones almost immediately. She was one of the warmest people I'd worked with, and she was so impressed and appreciative to be feeling so well on the day of her operation. The following morning I heard an enthusiastic report of the delicious meals she'd consumed. Typically, we'd send her home after one day, but her white count bumped ever so slightly. This is to be expected after a robotic procedure, but our attending felt more comfortable keeping her in the hospital for one more day of observation. On post-op day 2, I went in to check on her. Expecting vivacious descriptions of the hospital cafeteria delicacies, I was shocked to find her sitting on the side of her bed, curled over herself, clutching the bedrails. She was diaphoretic and had emesis bags scattered around her within arms reach. She looked miserable. Overnight, she'd been overcome with nausea and had thrown up significant volumes. She was quickly placed NPO, and soon had an NG tube in place to decompress her stomach. Still, she was not improving. She failed attempts to discontinue the tube and advance her diet. Her family was very involved from the beginning of her admission. In fact, her daughter recently underwent chemo and a double mastectomy for breast cancer. That experience was still fresh. Her children were insistent that this was unlike their mom. They begged for a CT, or something to assess why their mom was not getting better. As the medical student, I did my best to educate them on our concerns, our plan for management, and the signs and symptoms we would be monitoring in her. I brought my Chief Resident to discuss these topics, as they still wanted a CT. She discussed why we manage bowel obstructions with NG tubes, shared our concern for an ileus and explained why in the setting of an ileus, a CT would be unlikely to change our management. The family felt reassured, but given her lack of progress the next day and the family's persistence, we proceeded with a CT. The results showed an incision site hernia with a mechanical obstruction. In this time, her pathology came back showing cancer, something we did not anticipate in her risk-reducing surgery. Given her new need for surgical staging and her hernia, she was taken to the OR that day. Her second post-operative course was complicated by yet another bowel obstruction (this time it really was an ileus). The NG tube helped significantly, and she took her time advancing her diet. This case was difficult for multiple reasons. First of all, she had multiple complications that needed to be addressed. Managing each obstruction episode required in depth conversations, stepping out of our typical standard of care to order a CT, and then addressing the hernia complication head on. Her family's health literacy was high, which meant there were many questions regarding clinical decision-making and approaches. They were amicable and pleasant, which helped matters greatly, and their questions were well-informed and appropriate. Occasionally, particularly when she was NPO, the patient would get frustrated and complain about her nurses. She'd subsequently apologize profusely; however, I found myself regularly towing the line between acknowledging her (extremely justified) frustration and defending the nurses who were doing their best.

Finally, the patient now needed chemotherapy. She herself was positive about the matter, stating she will do what is needed to proceed with treatment, feeling grateful that we could catch her cancer as early as we did given her "risk-reducing" procedure. Her daughter, on the other hand, had only

recently completed her chemo. She told us she had horrendous neuropathy, lost her hair, and was generally miserable. She was completely crushed that her mom needed to undergo that pain too. This dynamic proved to be a challenge because we needed to focus on our primary concern, the patient; however, the daughter was clearly yearning to unload, to explain her own experience and why she feared for her mom. In caring for this patient, I was able to witness residents and Attendings counsel her on the unanticipated post-operative complications, taking ownership for such events, answering every question, and providing useful information and next steps. The success off this counseling was confirmed by the patient's overall positive attitude and gratefulness for the duration of her extended hospitalization. I learned to acknowledge and provide support for extraneous family difficulties, while explicitly prioritizing my patient. Finally, this case was the perfect example of remembering our patients' lives and goals. Initially in her hospitalization, the patient was extremely eager to be discharged. She took great pride in her work, and taking time off was extremely challenging for her own sense of identity. In acknowledging this, the patient's fears decreased and she was able to be more involved in our recommended course of action.

COMMENTS: --, I appreciate your sensitivity to the complex intrapsychic and interpersonal aspects of this case. You insightfully picked up on how the daughter's recent difficult experience with chemotherapy would color her views and require some space simply to allow her to share her experiences. You also had a great insight that the diagnosis of cancer threatened the patient's sense of identity and she needed someone on the team to recognize the importance of incorporating her goals and values into her treatment. Bravo.

This is one of those situations where the family demands something outside of the standard of care. The medical team feels it is unnecessary/ inappropriate, but eventually concedes when the patient does not improve. And voila an unexpected cancer is discovered. Obviously, this does not mean that patients and family members should run the show; but it does mean that it can be valuable to think outside the box and seriously consider suggestions even when they come from left field.

All in all, I was impressed at the good communication between patient, daughters, and medical team. I was also impressed by the way the team adapted to changing circumstances - unexpected complication, unexpected cancer diagnosis, unexpected psychosocial issues and family dynamics. This ability to be "light on your feet," to alter your plans based on what is happening on the ground is an essential part of good medicine, and I'm glad you had this opportunity to be part of such an experience first-hand.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

The patient experience I encountered during my time on my medicine sub internship. The patient had presented to the hospital with shortness of breath and fatigue every time she would stand. She had been worked up thoroughly with negative findings by her outpatient physicians including a full pulmonary and cardiac workup. She was at the point in her workup where her outpatient specialists recommended a cardiac catheterization with a follow up lung biopsy if the results were negative. So, she came to the ED at the encouragement of her husband and was admitted to the medicine ward for workup of shortness of breath with desaturation. When interviewing the patient, it was clear that something was off as the husband continued to speak for his wife, the patient, which went on throughout the interview. As we neared the end the dropped that they wanted a cardiac catheterization and a lung biopsy before they would leave the hospital. I told them that it was unlikely that we start but doing more minor tests before proceeding with the mentioned procedures because they carry a much high risk of adverse events. The following morning proceeded as usual; the patient had normal vitals throughout the night no problems at all. When we broached the topic of continuing her workup as an outpatient because she had done fine while in the hospital was when the dramatic conversation began. The husband flew into a fury demanding that she get her full workup or they would sue the hospital and refused to leave. I sat with them over several days discussing her care, what could be causing her symptoms, and how we should proceed. The top of my differential for her was anxiety as she would have the episodes occasionally when she would stand, and she had no difficulty under a walking stress test while I walked around the ward with her and telemetry on. After many discussions cardiology said they would do the cath which provided negative results. Then they wanted to undergo with the lung biopsy which is where my team drew the line. Ultimately after many conversations and education we agreed that a lung biopsy was too dangerous and recommended a full psych workup prior to proceeding. The patient after much back and forth agreed to the plan and she was discharged home.

COMMENTS: --, this was a complicated stuation, and I particularly respect the role you played. spending time with the patient, trying to understand her and the source of her symptoms. This was really about saving the patient from herself! From your description, it does sound as though these symptoms were more anxiety-related than caused by organic pathology. Some complex marital dyamics were also in play. Further, it sounded as though outside specialists, no doubt frustrated at not being able to resolve the patient's issues, encouraged their hopes that invasive and dangerous diagnostic procedures would provide answers.

None of this excuses this couple's demanding and difficult behavior, but it helps remind us how confused and desperate they must have felt. The husband, as sometimes happens, probably felt he was protecting his wife and ensuring that she got the best possible care. The team did a good job of holding the line in terms of rampant testing, and achieved an impressive concession on the part of the patient by negotiating a psych workup.

In these cases, as we heard from Dr. X, it's important to convince the patient (and family member) that we take their concerns seriously, that we believe they are suffering, that we are not trying to save money by shortchanging their work-up, and that their wellbeing is our highest priority. When

the patient feels you are on their side, it is more likely that they can set aside their mistrust and at least listen to your perspective. Clearly, when this patient shifted from lung biopsy to psych eval, it was because you'd overcome her certainty that biomedicine could provide all the answers. Despite the challenges, it seemed as though you were able to point this patient in a healthier and safer direction.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

When I was on my sub-internship, I worked with a resident who was challenging to be in a team with. The first warning sign was when I introduced myself, they expressed how depressed they were moving far away from home. I didn't think much of it, but I just apologized and expressed that I hoped everything would fall into place for them. As the week went on, I noticed that patients were affected by their own projections onto their patient. There was a patient who misunderstood what resources, such as a walker and oxygen tank, would be readily available for her upon discharge. The resident's response was to yell at the patient and condescendingly tell her that there was nothing they can do for her, while in behind closed doors, tell the team that the patient was "borderline and I don't feel sorry for her because she's fat and that she can't fix her obesity." I was taken aback by the dehumanizing and dismissive statements that this resident was saying. I wanted to help, but I had so many other tasks to finish with my patients. Luckily, the 3rd year medical student was available to mediate the situation and the patient was understanding and agreeable to be discharged. I thought they were having a bad day, and let the situation go.

As the remaining weeks continued, I started to notice the resident becoming more passive aggressive towards the medical student such as expecting them to finish their notes in a short amount of time and including yelling at me when I offered my help, but couldn't ultimately find a satisfactory solution for them. Intermittently, they would continue to share how depressed they were and at times, shared personal information such as their dating family life at inappropriate times. Sadly, they shared they tried to seek mental health help, but there is no time during wards. At this point, I knew I had to talk to my team leader about my concerns about this resident. I talked to the senior about the resident and it turns out that we all had the same concerns and that this was not the first time. Ultimately, we were able to get other leadership involved to make sure they have the resources to seek help and check in with them. At times, I feel ashamed for not addressing this earlier in the week and I wish that I addressed it earlier. I was attempting to give her the benefit of the doubt, but how long do I wait to ensure that they find help or how many people did I harm by not talking about this earlier? How do we take care of ourselves when the system limits the time and resources we have to seek help?

COMMENTS: --, what strikes me is not that you waited a few days to initiate some interventions regarding this resident, but that you were incredibly proactive in seeking to manage the damage they were doing to patients, medical students, and themselves. IMHO taking a few days to assess what was going on was not inappropriate and not something about which to feel guilty. And, while those days were passing, you guided the 3rd year to correct the misunderstandings of the patient; you tried to support the 3rd years as best you could; and you extended empathy toward the resident themselves. When you determined this was a persistent issue and not a one-off bad day, you did exactly the right thing to seek help from the team leader and ultimately from higher-up administration as well. I'm very impressed by the way you handled this difficult situation. The real harm to others comes when we see serious problems and NEVER speak up. Then problem behavior persists and the damage perpetuates patient after patient, student after student. Due to your efforts, this dysfunctional and damaging strain was interrupted.

Your final question demonstrates the empathy you had for this resident, who sounds depressed and perhaps burned-out as well. They needed help, yet the training system only imperfectly supports the needs of its physicians. It is still true that medical students, residents, AND physician faculty too often feel like they must soldier on, that forcefully asking for help is a sign of weakness or makes them somehow unqualified to be a doctor. Nothing could be further from the truth. One of the most important skills a physician develops is to know when he or she is out of their depth - in terms of knowledge, technical expertise, or personal coping - and to use that awareness to seek guidance from others. I pray this resident gets the help they need. You should be proud of the role your played in bringing this situation into the light.

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Patient Experience Reflection

"How's 401-2 doing?" asked my senior. Accustomed to the manner with which we address patients, as numbers on an overflowing list, I answered, "almost ready for discharge," a smile escaping, proud of how far along Shad come. For over 2 weeks I cared for S, watching him progress from day of admission to day of discharge. To some, 401-2 was the previously healthy 3 weeker with right elbow osteomyelitis. To me, he was much more. S was a beautiful baby boy with a serious medical condition at the fragile age of 3 weeks. His story was complex, layered with many nuances, including an uninsured family visiting from China that spoke only Mandarin, acquainted with an entirely different healthcare system. I owe this family a lot. I was fortunate enough to have had the opportunity to manage S's medical care, learning the protocols and basic medicine we apply in caring for incredibly young patients. I had lengthy discussions with Infectious Disease physicians and orthopedic surgeons on the appropriate management of my little friend, helping cultivate a plan that would provide S with the greatest chance of a full recovery. But I also learned how to navigate discussions when these plans collide with the realities of patients' complex social situations. Upon diagnosis of the bone infection, S's parents were eager to leave CHOC and return to China to complete his care. While some were quick to judge, I spent many hours over several days explaining the gravity of S's situation and the danger it would place on him if he left our facility. I sat with mom as she cried, divulging on the financial burdens this would place on their family. I listened to conversations with our case manager/social worker to see how we could best accommodate their unique situation. I welcomed dad as he traveled from China to be with his wife and child. I congratulated mom as she found temporary insurance and a place to live, and I shared with both the progression of S'S mri imaging and improving lab values. Through my daily interactions with S's family, I learned that devising medical plans for patients is oftentimes easy-what we spend years of medical training perfecting. It is the communication, the overcoming language and cultural barriers, and the unraveling of patients' complex stories, that is challenging. Every morning, I reflected on what it would feel like to be in another country unable to not only understand the complex medical jargon but the simple hi's/bye's/and how are you's. And with that in mind, despite the overflowing lists we often complain about, I rolled my iPad translator into S's room every morning and afternoon and patiently listened as his family read off the lines of foreign Chinese characters from their notepads, answering as many questions as I could. This formative experience reinforced my desire to become not only a medically equipped pediatrician but one who is socially aware, who is culturally competent and who can place myself in families' shoes to truly understand where behaviors, reactions, and intentions arise from and address them empathetically and appropriately.

COMMENTS: What a lovely and touching essay this is. What I found most compelling was the gratitude that you felt toward this patient and his family, although the difficulties of the circumstances could have easily prompted other feelings. I loved your openness to learning all you could from this little fellow, not only the complex medicine, but the even more complex ramifications of cultural and social factors.

Despite challenges and a threatened AMA, you managed to remain empathic in the sense of truly trying to enter in to the family's perspective, listening to their desires and fears, and trying to accommodate their wishes as much as possible while ensure the health of baby S. You kept them apprised of labs and imaging, and struggled through the limitations of iPad translation.

I'm sure some of your motivation was due to your planning on a career in pEDS; but in my view, a large part of your actions with this patient and family speak to the kind of person you are and the kind of doctor you will be, never forgetting the complex interplay between social and cultural elements and biomedicine. Your future patients will be fortunate to have you as their doctor, --.

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One difficult encounter I had during my clinical clerkships was with a patient on my 3rd year psychiatry rotation. The patient had schizophrenia and mainly expressed negative symptoms. He was initially friendly to me but over the course of about a week, became increasingly rude to me and refused to talk to me. This hostility worsened in the second week when he raised his voice in a threatening manner during one of our encounters.

Given that I still wanted to follow the care of this patient, I met with the attending physician and resident to come up with a plan so that I could still engage in his care. It was decided that I would interview the patient in combination with the resident. This way the patient would only have to undergo one interview in the morning and this may make him feel less threatened. However, the plan did not work and the patient became increasingly hostile to both myself and the resident.

I learned from this patient that not all situations can be solved even with a proper plan. This difficult encounter demonstrated to me that certain situations are so difficult that even seeking advice from individuals with more knowledge and experience would not resolve the problem.

On a positive note, this encounter taught me to put into practice one concept we have always been taught in medical school, “when in doubt, ask questions”. Since I was unsure of how to approach this patient after he became more hostile, I immediately went to those with more experience for advice.

COMMENTS: --, I find your conclusion very wise. Not everything can be controlled through a "proper plan," althougH thinking through alternative ways of approaching a problem give you the best chance of addressing it. You also realized that sometimes even people with more experience or knowledge don't have a perfect answer. Both of these steps were really good ideas (consulting with another, devising a new approach), and often they will have a positive outcome. BUT NOT ALWAYS. This is when we need to practice acceptance. We cannot always change things for the better, no matter how great our efforts. However, we can demonstrate acceptance not tinged with anger or blame.

I wonder if you were ever able to discover what caused the patient to become increasingly rude, withdrawn, and threatening. Of course, I realize that with a patient with schizophrenia, this is not easy. His deteriorating behavior may have had mostly to do with his inner reality. Still, whenever possible, demonstrating a caring curiosity about what makes patients behave as they do can sometimes provide a key to guiding a way in. BUT NOT ALWAYS.

Finally, I agree that a team approach is always productive. First, it provides useful brainstorming and different perspectives. Secondly, it creates allies who may succeed where you are struggling. And third, it provides support when things do not go "according to plan."

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I have had a few difficult patient encounters in the past, but one in particular comes to mind. A patient came in to the emergency department in distress and screaming that she was in pain. The attending and I attempted to obtain collateral information from family members who came to the ED with the patient since the patient was not able to participate in the interview. We gathered the information we could and began to work up the patient based on a differential diagnosis we had developed together. We walked away from the patient and her family members and put this plan into action. After a few minutes we returned to perform an ultrasound on the patient without discussing the reason for the ultrasound with the family members.

After a few minutes, the family members began to get impatient. The patients sister then approached me and appeared angry asking "Can you please tell us what is going on with my sister? No one has said anything to us about what they think is happening." At this moment, I realized that we had not discussed our plan with the family members and had not attempted to answer any questions they had prior to initiating our plan. I apologized for our lack of communication and discussed our plan with the family members and attempted to ease their concerns. From this encounter, I learned how important it is to keep family members informed, especially in frightening potentially life threatening situations.

COMMENTS: Great point, --, and I can imagine how in the intense, pressured environment of the ED it can be easy to lose sight of worried family members. Nonetheless, as you discovered, families have feelings too, and unless you keep them in the loop, they may complicate the care of your patient by becoming angry, demanding attention etc.

What I admired in your essay was how you handled this oversight. It would have been easy to become defensive - we're busy, we're taking good care of your loved one, don't bother us - but instead you instantly recognized the omission that had been made, you owned it,apologized, and took action to make sure the family was informed about the plan. You don't say whether the family was mollified, but often they are, and it is possible to move on. However, along these lines, there is a Buddhist saying that when you drive a nail into a piece of wood, you can still pull it out but it leaves a hole. It is better not to drive the nail in in the first place. In this case, the hole that might have been left is suspicion or mistrust of the team, so that you all would have to work harder to make the family feel included. Lesson learned - keep the family posted whenever possible and you will save yourself trouble down the road. Thanks for your clearsightedness about this situation and your straightforward, humble way of remedying it.

AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

On my Pediatrics rotation, I dealt with an upset mother. I was evaluating the patient, a 2-month-old, for a Well Child Exam. As I asked the patient's mother about the baby's bowel habits, she disclosed that the patient's last bowel movement was over 1 week ago. I became concerned that the baby could possibly be constipated due to impacted stool and in a split second, translated this into what I thought would be layman's terms. I mentioned the possibility of an "obstruction," and immediately, the patient's mother became defensive and retorted matter-of-factly, "No." I tried to diffuse the sudden tension by explaining I had only mentioned a thought based on anecdotal experience and not a definitive diagnosis. She seemed to dismiss my explanation, still appearing defensive and distrustful. I moved on with the interview, but just a few minutes later, she abruptly chided, "You know, you really made me worry as soon as you said the word 'obstruction.' You really shouldn't have said that."
Instinctively, I felt heated and offended. However, I did my best to appear and speak calmly. I immediately apologized and validated her distress. I explained that I was merely thinking out loud and had no intent of worrying her. Then, she disdainfully and authoritatively explained, "Most people would be shocked by the word obstruction. You should really be careful with what you say. I panicked inside when you said that." Again, I validated her reaction and attempted to discover why she was so upset. I learned she was a nurse practitioner and that, understandably, she connotated the word "obstruction" with "potential surgical emergency." I moved on, and for the rest of the encounter, the patient's mother was more agreeable, but I perceived hostility and distrust and remained on edge, desperate to finish. In the end, I never told my preceptor that I upset the patient's mother, although I did mention she was an NP.

Looking back, I realize that I perceived her criticism as an attack. I felt disrespected by her "schooling" me, despite her presumably having more clinical experience as an NP (for what it is worth, she was not a UCI employee). On one hand, I respect her feelings and am regretful for having caused her distress, but on the other hand, I feel that she insulted me - if not by frankly rejecting my credibility, then by her condescending tone and spiteful attitude (though I recognize my bias). Overall, I am satisfied with how I dealt with the situation. After much ranting to my SO about this encounter, I have learned 1) to be mindful of a patients' medical literacies and how certain words or phrases may be triggering for them; 2) to consider saving my impression until the of the exam or until staffed with my attending, especially if I am uncertain; 3) that patients and their families may be a lot more preoccupied or anxious than they appear; 4) that in dealing with difficult patients/family members, validating their emotions and remaining calm and professional are crucial; 5) to try recognizing pride and power and not let them interfere with listening or valuing other's concerns

COMMENTS: A difficult encounter for sure, with lots to learn. The mom's initial reaction was interesting. Fortunately, she explained why she'd reacted so strongly to the word "obstruction." It frightened her.

Understandably, her response made you feel attacked. Fortunately, rather than reacting with instinctive "fight or flight" you behaved in a professional manner: you apologized for the distress you caused her, validated her reaction, and showed appropriate curiosity about why she felt so strongly. This yielded the information that the pt's mom was an NP. This fact may have contributed to the difficult interaction in other ways: e.g., as a health professional herself, she may have felt guilty that she had not taken her baby's lack of poop more seriously. It is worth considering that her "condescending tone and spiteful attitude" may have had at least as much to do with her (defensively) as with you.

It is easy to feel disrespected, especially when the patient behaves in a rude, demeaning manner. At the same time, while it is no fun to be "schooled" by another, often we do have something to learn from them, even if their teaching methods are not ideal. In this case, I think you extracted exactly the right lessons: 1) Language is so important - you can't predict how everyone will react to your words, although it is always important to take into consideration circumstances (such as history of dv or a recent family death) that might increase the likelihood of certain words being triggering. 2) You are right that sometimes it will make more sense to have a more authoritative voice addressing diagnostic issues. However, even as an experienced physician you may find yourself sharing possibilities with a patient. Usually this is most appropriate when the patient initiates such speculation - and again, these tentative thoughts should be labeled as such, and presented in a way that considers how much justification there is to alarm the patient 3) Bravo for the awareness that patients and families are usually worried, frightened, out of control, helpless even when they seem to be holding it together. 4) Yes, validating pt emotions is ALWAYS a good move. This is not the same as telling them they are right, but simply acknowledging that people's feelings are neither right or wrong, they are just there. Acknowledging them is one of the best ways to move past them. And finally, 5) Bravo for committing to qualities of humility and service. When we set our egos aside, we can always learn something even from the most obnoxious patient. You obviously learned a great deal. Now make a commitment to take your SO out to dinner!:-)

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I first met my patient during a rapid response called for respiratory distress. He was in his early sixties but appeared older than that. He was extremely thin and his skin looked fragile. The hair on his head had receded and now just covered the areas above his long ears. Most striking was the terror in his large round eyes as he was gasping for air. This was one of my first weeks of my ICU rotation and I dove right in. He was a patient on the heme/onc service with a history of acute myeloid leukemia that had presented with weakness found to be a recurrence of his disease. He had a fever and there was concern for both gram-negative sepsis or pulmonary embolism. The decision was made to intubate the patient due to impending respiratory failure. I did not see him alert again during his hospital stay.Over the course of the next week his condition deteriorated. He developed kidney failure and required continuous renal replacement therapy. As I examined him each morning his neurological exam grew worse. His platelets had dropped precipitously and there were many small hemorrhages in his brain. His large eyes would not stay closed, growing more and more lifeless. Unfortunately, his wife had passed away some time prior and his two young adult kids were left with the decisions regarding his care. They sat in the room with a treatment team consisting for palliative medicine, heme/onc, and our ICU team. We talked about the futility of treatment and though they struggled with the idea of losing their father they understood that medical treatment would not help him in this situation. However, they conveyed that no matter the situation their father would have wanted continued medical therapy. This was tough for both his family and us as the treatment team. The patient lacked any sign of brainstem activity on exam and required ventilator support and continuous dialysis. Despite full spectrum antibiotics he continued to require more and more pressors. He would not survive if coded as none of his underlying conditions were controlled. Over the course of the next week we had more meetings with family to reassess goals of care. Each morning I saw the patient and was quite disturbed by his current state. I could not imagine wanting to continue with all the supportive measures required. And each day his eyes appeared more lifeless, bulging from his head and dry as could be. We tried taping his eyes shut but they would continue to open on their own. Eventually family from out of state arrived and helped the children come to the decision to change his code status to DNR and transition him to palliative care. This case was difficult for me because I watched this patient deteriorate daily. His eyes made it seems as if he were decaying while alive. I understood the children's desire to go by their father's wishes and that they knew him best, but at the same time it seemed almost paradoxical. It leads me to question what our idea of death and its binary nature. To me the patient was long gone before the supportive measures were pulled and he could have been saved unnecessary pain as well as strain on his family.

COMMENTS: --, this was indeed a terrible situation and one that, unfortunately is still too common. On a simple level, it speaks to the need for advance directives and a POLST. However, suppose the kids were right, and his AD said, do everything possible for as long as possible. Those are the physicians' legal marching orders (I do think issues of medical futility can be invoked in such situations, but this is complicated). Taking a step back, we come to the issue of better education for our citizenry about life, death, quality of life etc. I think very often when people say, do everything possible, they are thinking of themselves more or less as they are at the time, maybe with some pain

or weakness, but still essentially THEMSELVES. Was that patient still himself? When he told his children he would want everything done, was the scenario you witnessed the scenario he envisioned?

These are really tough things to address, and unfortunately our cultural phobia about death (which affects not only patients and especially family members but also too often physicians) makes these essential conversations very difficult to have. Many patients (in fact the majority) fill out ADs without the guidance and honest clarification from their physician, and it is worrisome to consider whether their expression of wishes is truly "informed." Until it is, we will continue to have heartbreaking situations such as the one you describe.

I do think that the team deserves to be commended for continuing to meet with the young adult children and dialogue with them. Sometimes it takes time for families to process the true nature of the situation, to consider whether they are truly honoring their father's wishes by keeping him alive in this state. Understandably, adult children can feel guilty that if they agree to palliative care only, they are hastening the death of their family member or are abandoning them in their fight for life. These misguided ideas can be reframed gently, offering family members another way of thinking about end of life.

Ideally, these conversations should start long before death, so that in the face of impending demise, everyone is better prepared. Of course, there is no way to be "prepared" for the loss of a loved one, but if we were more able to openly discuss what we hope for at the end of life, I think such scenarios would diminish.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I experienced this difficult patient encounter during a clinic session. As part of the context of this situation, the clinic was behind by about an hour. These patients were returning for follow up after a procedure for refractory gastroesophageal reflux disease, and the patient was experiencing chronic pain following the procedure. When I walked in the room, it was the gentleman and his wife, and they were both clearly frustrated.

As a medical student, it is our job to take a complete history in order to report back to the attending. I first apologized about the wait, which they accepted. However, when I began asking about the patient's symptoms since the last visit, they expressed their frustration that they had to tell the story multiple times and that they shouldn't have to rehash it for multiple people whose role they didn't fully even understand. Both of them together kind of reaffirmed each other's frustration and did not help with the situation.

In order to handle this situation, I expressed that they seemed frustrated, and that I was sincerely sorry for all the difficulty they had been having over the past few weeks. I used one of my phrases that seems to help a lot, namely "I wish there was something I could do to change the situation" which shows I am on their side. Finally I expressed the purpose of my own role in the encounter, that I am a medical student and I wanted to make sure I got all of the information in order to formulate a plan with the attending physician. After clearly and calmly expressing my sympathy and demonstrating I heard their frustration, they relaxed and actually began asking me about medical school, my college, and I was able to further relate and engage with them, and they seemed happy to get to know me. Finally I was able to slip out and report back to my attending, and when we both returned the patient and his wife seemed to have worked out the frustration and the visit went very smoothly.

I learned that whereas we often fear that we can lose patient rapport, sometimes permanently, through interpersonal errors, I found that we can also salvage situations by drawing on basic principles including listening, empathy, and relying on tried and true phrases to alleviate upset patients.

COMMENTS: Insightful essay, --. I really like your "wishing" phrase (did you happen to catch Dr. X's talk? She uses a similar technique, and as you say, it shows that you are aligned with your patient). I also very much endorse your concept that, unlike say amputating the wrong leg, or a fatal medication error, most interpersonal mistakes are salvageable. Even if you (or someone else) has inadvertently frustrated or angered or insulted the patient, by simply acknowledging the situation and nondefensively owning your regret (not sorry but, followed by excuses, but simply a heartfelt apology), things usually right themselves.

Also, as you no doubt recognize, patients who complain about delivering their history multiple times over have a legitimate gripe. It is a taxing process, especially when the patient feels miserable to begin with. You offered an excellent reframe to the patient and his wife - they were helping you become a better student and future doctor. You could see that this idea delighted them and they ran

with it. Sometimes it helps to show patients how they benefit from your history-taking - you can streamline the physician interview, saving time, while bringing to the attending's attention what is most important to the patient. The main idea is to offer the patient a more positive way to see the repetitive questions.

Your essay demonstrates both skilled competence and heartfelt empathy. You sound well-prepared for next year!

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

When I think of "difficult" encounters, my mind instantly starts sifting through unexpected deaths in the PICU and disgruntled parents in stuffy rooms on the wards. However, I am instead going to discuss a less emotional but probably more pervasive type of difficult encounter involving nurses and residents (and by association, medical students).Since starting medical school, I have been intrigued by the often unnecessarily tense interactions between residents and nurses and wondered what is at the core of this tension. Is it all a product of sleep deprivation? Is it that residents do not understand the role of nurses and nurses do not understand the role of residents? Is it that nurses feel frustrated receiving orders from often younger and less experienced individuals? Is it that there is not a structured way for each party to express their appreciation for one another? I have great respect for nurses and take every opportunity I can to learn from them—they have taught me invaluable skills including how to swaddle, soothe, and feed newborns. But despite my best efforts to be as kind, receptive, and available as possible to nurses, many of my interactions still feel charged with negativity even before words have escaped my mouth.One interaction captures this tense dynamic. It is widely known that it is our job as medical students to print patient lists for the whole team before sign-off in the morning. One particularly hectic morning, the resident workroom was packed to maximum capacity and every computer was in use. I opted to stay out of the way and instead printed the lists in the nurse's station. I grabbed the sheets off the printer and left the room, but quickly returned to staple them. When I returned, the room of nurses became palpably quiet in the same way that a table of high school girls at lunch becomes quiet when the person they were gossiping about appears. For a split second, I considered ignoring this awkward feeling, grabbing my stapled lists, and leaving However, I was really tired of the often juvenile dynamic between nurses and residents and was feeling uncharacteristically confrontational. I nicely asked, "Am I not supposed to use this printer?" which appeared to catch the whole room off guard. You would have thought that it was the first time that someone sensed and responded to their frustration. After a moment of silence, one noticeably frazzled nurse explained through jumbled words that the funding for nursing and medical education is different and that they would prefer if we all use our own separate printers for that reason. I apologized and shared that had I been aware of this, I would not have used the printer and would keep this in mind in the future.

Perhaps they were caught off guard initially, but I was the one caught off guard by their response to me being slightly more confrontational than usual—they were all suddenly very grateful that I directly addressed the issue and even apologized for the awkwardness they created. I felt for the first time like me and the nurses in the unit were seeing eye to eye. I was stressed, probably flushed with beads of sweat on my forehead, and tired—I was just trying to do my job for the medical team. And the nurses were probably tired of their printer running out of ink and paper but did not directly express this to the residents or medical students before. I realized that if we all just take a few seconds to understand where each other is coming from, nurse-resident relationships would probably vastly improve. Although this was not the most "difficult" encounter in the typical sense, I think it demonstrates how our small daily actions can really affect the camaraderie of a medical team.

COMMENTS: --, this is such a great issue, and I'm delighted you chose to write about it. I have heard this from many students and residents, and I have also talked to a few nurses about these tensions, which definitely do exist.

Not to minimize individual quirks and annoying personalities, but I think the problem is structural and systemic. Nurses do feel undervalued, underrecognized, and underpaid in the healthcare system; and it is easy although unfair to vent their frustrations on young doctors or students. I think the approach you take is exactly the right one - showing respect, being willing to learn from them - but it can be very hard to overcome these real and perceived grievances.

I also respect that you challenged the code of silence. I find it so strange that, when these tensions are palpable, no one says anything. Thus nothing gets resolved, and hurt feelings fester. I would not label your behavior as confrontational - rather I would call it an authentic request for understanding. I suspect that you are right - prior to your query, probably very few residents bothered to try to figure out what was going on.

Through you initiative, despite everyone being tired and stressed (which is precisely the conditions under which teams tend to fall apart), you were able to start rebuilding that sense of all pulling together. You are so right that taking a few minutes to honor the other's point of view (which is not the same as agreeing with it) punctures hostility and creates trust. We all just want to be seen and heard. I love that you took the time and had the courage to do this for the nurses on your team.

AOD 2019.20.ASSIGN 1.DIFFICULT ENCOUNTER

During a third year clinical rotation, I had a challenging experience working with a particular resident on the team, whom I will call Carl. From day one, Carl was cold to me and the other medical student on service. He appeared disinterested and checked out, which made collaborating difficult. We tried to engage him by showing our interest in learning and desire to help the team; however our efforts were never recognized and we were often shut down by terse responses. Though not ideal, this was a workable situation. What was most difficult about working with Carl, however, was that he was often passive aggressive, condescending, and rude. For example, on our short call days, we would remind him that we were supposed to leave by a certain time, and he would ignore us. When asking again what more we could do, he would smirk and say it was up to us whether we wanted to stay, if we cared to prioritize our learning. This often left us sitting for multiple hours in silence, with no work to do but not able to study or leave.

At first we considered talking to the interns about our experience, to see whether they may be able to talk with Carl. However we quickly realized they were just as perplexed—and sometimes intimidated—by him. This was clear by how quiet and tense our workroom was; there were no extraneous conversations, no unnecessary questions, no breaks. Therefore, we decided to reach out to the rotation director to resolve the situation. This was not a decision we took lightly, but we could not think of any other productive option. We told her about how we \felt ignored and that our time was not being put to good use. We also mentioned that Carl, from our experience, was not an effective team leader. The course director was surprised, since she had worked with him in the past and thought he was quite competent. We discussed how we felt he worked well with attendings, whom he respected, but failed to involve anyone whom he thought was lower on the hierarchical totem pole. We did not doubt his competence, but were honestly concerned about his professionalism with patients and colleagues. The director decided to check in with Carl, not raising our specific concerns per se, but to review expectations for his role as senior resident. She also assured us that he would not evaluate us for course grades, so we could feel more open to address concerns with him upfront.

We were given the choice whether we wanted to switch teams for the final two weeks of the rotation. Though we were not optimistic that things would change drastically, we knew we were supported by the clerkship faculty, which made a big difference. We directly addressed the medical student schedule concerns with him and asked him to delineate his expectations of us during our rotation. While we did not get any substantial answer from him, we gradually garnered a

bit more trust and respect from Carl. More importantly, we also learned not to care what he thought and instead focus on our learning priorities.

This was the first (and so far, the last) time I have had difficulty working with a colleague in medical school. I learned that a direct approach really does solve issues efficiently and effectively. We had been afraid to speak up, but ultimately doing so improved our experience and hopefully the experience for future medical students who will work with Carl. The situation taught me the inherent value of being professional and respectful, even when those tenets are returned sporadically. I was able to leave the rotation feeling confident in my problem solving skills and in my ability to work with a wide variety of people.

COMMENTS: It is hard to read about a situation where the senior resident is not only a poor team leader but also abuses his power by behaving in sarcastic and demeaning ways to those lower down on the medical hierarchy. In my view, you did exactly the right thing in approaching the clerkship director. That's why this individual is there, to ensure that your clerkship experience is productive and supportive.

I'm also glad you were able to directly raise the issue of your schedules with this resident. Although such difficulties are not common, they will arise in the future, and practicing learning how to handle them is essential. People often tend to stew in silence or grumble to others; although very natural, neither of these approaches tends to be satisfying in the long run. As the recipient of the resident's harshness and scorn, you end up feeling helpless and victimized. The resident himself learns nothing.

By speaking up to the clerkship director, you brought to her attention a less positive side of this resident, which she could assess further and if necessary address, using her authority and greater experience. By speaking up to the resident, you compelled his attention and reminded him of his responsibility to you as learners. Clearly, you conducted yourselves very professionally, even if he had not, and earned at least a modicum of trust and respect. As you realized, what was most important was discovering that you had at least some control over the educational experience.

I'm admiring of the way you handled this difficult situation. I guarantee you that, in the future, you will need recourse to the same skills of direct communication that you used so well here. Glad you had this practice :-)

ART OF DOCTORING 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

"You were totally off, completely wrong."
A phrase no one wants to hear, especially not a healthcare provider. The mom who said this to me was the mother of a patient I had seen a few weeks prior in Urgent Care Clinic. The patient was a 9-year-old adorable, previously healthy boy who presented initially with a chronic, dry cough and non-specific abdominal pain. I remember taking the history, presenting the patient to my attending, and feeling rather perplexed about the case in general. Thinking through the common causes of chronic dry cough in pediatrics in the context of this previously healthy patient, my attending and I had GERD as our top differential diagnosis, and ordered the necessary diagnostic lab tests to confirm. I recall saying goodbye to the patient and his mom as they walked out of clinic, feeling rather uneasy. Nothing quite fully explained his constellation of symptoms, and I did not feel satisfied with "GERD" as the most probably cause. However, as with many things in medicine, there were unanswerable questions with the data we had at the time.

A few weeks later, the patient and his mom showed up in clinic again. As I was chart reviewing, I saw that he had been to the ED recently as well for fever, shortness of breath and worsening cough. At that time, they performed a chest x-ray, diagnosed him with pneumonia and sent him home with a z-pack (azithromycin). When I walked into the exam room, the mother was visibly upset. Since we had seen him, his health had significantly deteriorated and he was now unable to tolerate anything PO, including his meds. It was clear that he was going to need to be admitted to the hospital.

I sat down in the exam room, and listened to the mother. As she voiced her frustrations, concerns and anger, I affirmed and validated all her emotions. I apologized for not knowing that this was going to be his course, and for getting the diagnosis wrong at the first visit. I promised her I would continue to be her son's advocate and ensure he received the best care moving forward.
By the end of the visit, the mom was thanking me for my care for her son. I was both relieved and grateful by her eventual change in demeanor – from anger to gratitude. It was a great reminder as to why I love the field of pediatrics, that even with some of the most difficult patient encounters, more often than not we are working towards the same common goal of ensuring the best healthcare possible for children.

COMMENTS: You deserve a lot of credit for the way in which you absorbed the mom's anger. It is hard when you are attacked not to be defensive, or to escalate the situation, both of which are poor, although understandable, strategies. Instead, you did everything right: You validated the mom's

feelings; you apologized for not getting the diagnosis right; and despite all the upsetness, you affirmed that you would continue to be there as an advocate for the kid. Very impressive!

This approach does not always "work" in terms of calming volatile feelings and enlisting the parent's/patient's support; but it is by far the best way to go. It conveys precisely the message that you articulate at the end of your essay - that both you and parent want the best for kiddo, and you are there to make that happen.

As you well know, a sick kid, especially a sick kid without a clear explanation, is every parent's worst nightmare. That does not give them carte blanche to behave in hostile, abusive ways, but it does remind us that all parents of sick kids can get a little crazy and to cut them some slack. In this case, you did exactly that with the result mom saw you were on her side, were pulling for her kid, and were committed to delivering the best care possible. Sadly, that is not the same as perfect care with perfect outcomes, which of course is what parents want. But your lack of defensiveness, your apology, and your perserverance will go a long way toward helping parents accept your humanness.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

A recent challenging encounter occurred when I saw a patient with chest pain in the emergency department. This patient had a moderate risk of acute coronary disease and completed several rounds of labs and EKGs. The results of the lab tests were good, but I recommended that the patient follow up with a cardiac stress test as soon as possible. This patient had previously been seen for chest pain with similar recommendations but failed to show up to their appointment for the stress test. The patient was offered observation to get a stress test done in the ED but refused as they did not want to stay until the following morning and were subsequently discharged. The next morning the patient returned with complaint. Again, the work up was negative and the same recommendations were made, and again the patient refused to stay for a stress test. This encounter was challenging as the patient continually refused to take the next step in treatment, and as a result was seen multiple times in the emergency department.

I had a difficult time discussing this with the patient as they did not seem to have an appreciation for how serious this condition could be, despite coming to the emergency department twice in two days. When discussing the goals of the visit with the patient, they stated that they simply wanted us to organize a stress test for them that same day with no waiting. They also refused to take steps to contact their own provider or attempt to establish followup despite having adequate access to care. Overall, I found it difficult to balance the role of the provider here. On one hand I wanted to assist this patient in getting their stress test and moving forward in treatment, but I could not offer the immediate stress test without admission that the patient wanted. Additionally, the ED was very busy that day and it would not have been appropriate to contact the patient's insurance and PCP on their behalf when several other patients were still waiting to be seen, especially when this patient had demonstrated that they were capable of making appointments themselves. I find it challenging to work with patients that are disinterested in their own health and unwilling to participate in their own care. Thankfully, during a lull in the ED flow, we were able to assist the patient in making an appointment for a stress test, and the patient assured us that they would make the appointment this time, and the patient successfully discharged.

I learned during this encounter that it is important to always make every effort for our patients, but that ultimately some of that responsibility lies with the patient themselves, and it is important to accept that they may not take the same view of their health as we do.

COMMENTS: This sounds like a very frustrating situation. You and the docs in the ED took good care of the patient, worked him up appropriately, and indicated the next step in the process (cardiac stress test). But the patient (twice!) refused because he did not want to stay overnight to complete the test.

All of this was occurring in a busy ED with other very sick patients who needed attention.

It is so puzzling to figure out what is going on here. On the one hand, the patient seems "disinterested" in his own health and "unwilling to participate in his own health care." On the other hand, he keeps seeking care (inappropriately, by coming to the ED, but he is asking for help). There

seems to be a disconnect between what the healthcare system can offer him and what he wants (immediate and convenient stress testing).

How can the gap be closed?

Fortunately, as you say, during a quiet moment, you were able to help the patient make an appointment for a stress test; and the patient's attitude seemed to have changed sufficiently that he was willing to follow-up. I especially respect that, after dealing with this patient twice in two days, you made the extra effort to help him. I suspect that what happened was that he finally trusted your assessment of the situation, he finally realized there was no alternative, and he finally accepted that you were doing your best to help him.

What is impressive and hopeful here is that the two of you started off coming from very different places about what needed to happen next, but with patience and persistence you closed the gap. You had to do a lot of extra work with this patient, but on the other hand you may have saved his life. You managed your frustration and exasperation in order to serve the best interests of the patient. This isn't easy, but it's what makes you a committed and caring physician.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

While on my PM&R sub-internship rotation, I had a patient in the acute rehab unit who recently underwent a femoral bypass graft so he was getting his surgical wound site drained by a "wound vac". The patient would constantly ask when he could take it off & we would inform him that he had to wait for the battery to run out, which would indicate it was a good time to remove it, & place dressings on it instead. He would tell us that we were wrong and that he would only believe that if the vascular surgeons who performed the procedure came by, examined the wound vac, and informed him that. He would be seen pulling on it and it was difficult to explain to the patient the importance of keeping it. In my head I thought "why is he not taking our word for it" as the vascular surgeons are understandably busy and don't typically make visits to inpatient rehab facilities. I would try to reason with the patient and explain that we are now the primary team and that our decisions were valid, standard protocol, and based on vascular surgery's recommendations. I even conveyed to the patient that we had called vascular ourselves and that I was simply relaying vasculars' responses to the patient's questions. The patient's family did not help matters as they actually gave us false information, claiming that the patient had inpatient appointments with vascular and that they needed to come see them.

After some initial frustration, I placed myself in the patient's shoes, thinking if I was very particular about my medical care, I too would want the respective, appropriate specialists to see me for certain issues. In order to resolve the situation, I decided to physically make my way over to vascular and beg for their assistance. I got confused looks and dismissals initially; eventually I spoke to the head vascular surgeon whom I had as my attending when I rotated through vascular service during my surgery rotation block only a few months earlier. He was understanding and told me he would be by with his team at the end of the day. When I saw the look on my patient's eyes as the attending reassured him it became clear to me that sometimes you need to compromise for the patient, within reason of course. It helped that the attending instructed the patient to listen to us from now on: "they get to call the shots".

From this encounter, I learned that as long it doesn't cross professional, ethical, financial, resource, or wellness boundaries, accommodating patients' desires and wishes goes a long way. If showing them you work together as a team with others to plan care, you gain their trust, which in turn leads to adherence and compliance, which benefits us all and results in the best outcome for patients.

COMMENTS: Awesome, --. You literally went the extra distance to get help from vascular. In my view, you did exactly the right thing. If you can accommodate the patient, and it is not terribly inconvenient or crossing the boundaries you mention, it is often the right move. The patient feels powerless and scared. They don't know whom to trust, but a big specialist who has performed a successful operation on them seems like the best bet. Partly they want the reassurance of the "expert"; and partly they are testing you, to see how much you will help them, to see if you are listening, to see if you care. Occasionally, in such situations, patients' demands will escalate, and then you need to establish clear boundaries. But usually is not the case. The patient is satisfied that you

are listening to them, and will typically accept your guidance more easily from then on because as you say well, you've gained their trust..

I also wanted to comment on the vascular surgeon's behavior. In contrast to his subordinates, he understood the issue and pulled himself away from I'm sure a very demanding schedule to help. Importantly, after reassuring the patient about the wound vac, he skillfully transferred his prestige and authority to your team. That was awesome as well.

I really admire the initiative you took in trying to solve this patient's anxieties and mistrust. You found a reasonable and ethical way to meet his need. It probably inconvenienced both you and the vascular surgeon a little bit; but it also created an adherent, cooperative patient which saved a lot of hassle and grief, and led the way to his receiving the best care of which the team was capable.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

My most difficult encounter I had during my third-year clinical rotations was with my surgery attending. One day after clinic she pulled me aside to tell me that I was a fault for choosing not to attend her evening case the previous Friday. She explained how it is implied in surgeon culture to stand and stay even if you can't see or touch anything. At first this was a total surprise because this attending was known for being friendly and wanting to teach students. From that day I felt as I was being singled out for the rest of my rotation, especially when a collogue told me that this attending spoke of me in front of the team questioning where I was and assumed I was being delinquent, when I was hustling on my way to the next case. In my head this I had many reasons that would suffice as proper reasons why I chose to assist the Intern on the floor instead of joining her case. Most significant being that there was no physical room to even stand near the patient. I noticed this when I stopped at the complete of my assigned case. There were previous cases with this particular attending in which I stood for close 10-11 hours scrubbed but outside the sterile field, unspoken to, untaught to. I believe I made the correct decision by choosing the opportunity to learn and perform floor duties with the Intern.

Afraid for my evaluation of the rotation, I vented to rotation coordinator. She explained that this a situation worth explaining to the director. I was very hesitant to because I did not want to complain but just inquire that I would be spared from misunderstandings. I was gently nudged into the room and spoke to the director. He replied that this would be the first of many misunderstandings in my career and that I made correct choice to seek the more educational opportunity. Later that week I spoke to my attending, apologizing for not going to her case but also affirming to her that I chose an weighted educational decision. I learned that misunderstandings or false perceptions will be part of professional interdisciplinary work. It is important to understand both parties and try to come to an understanding. If none is met then at least be proud of the decision you have made, as long as it's with good intent.

COMMENTS: --, although this must have been a very uncomfortable encounter, you found some valuable lessons for the future. I agree with you that it was primarily a values/culture clash, your pursuit of educational benefit versus the surgeon's expectations of student participation in the OR. Clearly she was offended and quickly made assumptions about your behavior that were unjust and demeaning.

In the aftermath of the surgeon's harsh reaction (including doubting you in front of the entire team), you had the courage to stand up for yourself and talk first to the rotation coordinator, then to the clerkship director, and finally to the attending herself. That persistence indicates your strong desire to resolve the issue equitably and help your superiors understand that there were two perspectives involved. I have great respect for your decision to bring this issue into the open, rather than leave it

submerged as so much is in medicine and medical training. It is only be communicating with each other that we can begin to understand each other.

In reading this account, it seems obvious to me that you made a good choice. Standing in an OR for 10 hours even if you can't see anything seems totally devoid of educational value to this non-physician :-). However, in different settings people will inevitably have different expectations and assumptions. To the extent possible, it can save conflict down the road to clarify as much as possible at the front end. Often you can find common ground. But when this is not possible, in the end you must make the choices you believe in, and accept the consequences. This will be true with colleagues and with patients too. I think you've shown that you are not afraid to take an unpopular path, if you think it is the right one. And that's good, because you will certainly need to do so again as your future unfolds.

AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

Now reflecting on this difficult and moving patient after having completed a four-week sub internship on gynecology oncology (gyn onc), I have even more conflicting feelings for this patient and her situation. While on gyn onc, our role as surgeons and oncologists was to help patients with their cancers but also to keep them well enough to be able to take one more chemo dose or one more tumor burden reducing surgery. We were health cheerleaders in often a difficult position trying to help women heal from a radical surgery but also having to manage the difficult complications that can arise from surgery. Like with the patient on IM, the end of life conversations are the hardest to have. I would say especially on the gyn onc side because often the women are middle aged and relatively healthy except for their cancer diagnosis and resulting sequela.

Looking back on the patient, I would not have done anything differently but now I have a deeper appreciation for the hard task on the gyn onc side to have those brutally honest conversations. As an oncologist often, they never want to lose hope for their patient. Patients and their families are often so hopeful that their family member would be the one in a million to be able to recover from their diagnosis. Talking to the gyn onc fellow, she was interested in a palliative care fellowship after gyn onc. I think palliative care rotations should be included in ALL oncology fellowships! Having the ability to navigate these conversations is tough and I think it would add to the richness of the physician experience to learn from palliative care providers. As I begin to think about residency and the challenges ahead, I think these difficult end of life situations help color for me how important these conversations are. Everyone has different expectations of their end of life. I feel like from my limited experience comfort care has been associated with "giving up." I think as physicians we can do better to reconstruct the narrative to help patients see comfort care in a way that allows them to feel as best as they can for as long as they can. It is not giving up, it is instilling the hope for a pain free as possible last few weeks/months to enjoy the fullness of their life. Hope to enjoy the time remaining with family, hope to reconnect with old friends or mend relationships.

Commented [JS1]: As a non-physician, I find this a very informative description of the different priorities Gyn-Onc physicians are balancing. Thank you.

Commented [JS2]: Well said. This is indeed a heart-wrenching conversation.

Commented [JS3]: And of course there must be different kinds of hope. One in a million is a certain hope, but perhaps patients can move toward other hopes such as some QoL with loved ones, reasonable pain control, non-abandonment by physician etc.

Commented [JS4]: Great idea. Oncologists are notorious for not being able to have understandable end-of-life conversations with patients (of course, there are many exceptions). The physician cannot have a real conversation on this difficult topic unless they themselves have reached some resolution or at least have deeply wrestled with end of life themselves.

Commented [JS5]: Good insight, especially the realization that there might be other ways of thinking about EoL: acceptance (of our finitude), strength (to face death), generosity (to spend quality time with family) etc.

Commented [JS6]: Well said. Make a better story so the patient feels not like a failure but a champion.

Commented [JS7]: Exactly, and by helping the patient and family see this, you can help them reframe end of life.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

The most difficult patient encounter I experienced was when I was working with a private practice family physician. I saw this patient several times and each time got more challenging. The patient was a 50 year old male who was coming to the doctor for insomnia and not feeling well. The first time I saw him was a fairly pleasant encounter. I took a history and did a physical exam. He was essentially complaining about various vague symptoms of not feeling normal and not being able to sleep very much due to anxiety. With the physician, we came up with a treatment plan and the patient was in agreement. However, the patient's wife was with him and she was quietly asking things and prodding him to ask for things. The main thing I noticed was when they were about to leave, she quietly said to her husband, "What about the Ambien?" Then the patient started asking for Ambien to help him sleep. The physician made it clear that he would not give the patient Ambien. The patient was a little frustrated but left without issue. Over the next week, the patient came back to the office to have blood drawn for his labs. This encounter was not very pleasant as he demanded to talk with the physician because he needed Ambien to sleep. He was raising his voice with the office staff and eventually the physician needed to talk with him to settle him down, but continue to hold firm on the no Ambien. The patient made an appointment for the week with the PA because the physician had not availability and would not be there. I volunteered to see the patient because I already had seen him and had an amiable relationship. He was without his wife this time and continued to endorse difficulty sleeping which was causing him significant stress. He also continued to ask for Ambien. I had discussed the plan with the PA before seeing the patient, so I spent significant time with the patient explaining why we were not going to give him Ambien and why we were going to give him Trazodone. He was not very happy that we were giving him an antidepressant for sleep. I thoroughly explained why we were giving it to him and that it was a commonly used drug for sleep. He was still frustrated but agreed to the plan. However, it appears he left the office and called his wife to tell her what happened and she got him riled up that he should be given Ambien and not an antidepressant. He came back into the office demanding to speak with the PA, who was in with another patient. He then demanded to speak with me, but the office staff did not want me speaking with him and told him I was unavailable. He continued to stay in the office waiting room for 15 minutes demanding to see us, but the staff told him that he would need to make another appointment as we were with other patients. He eventually left upset and frustrated.This was a very challenging experience for me because I tried very hard to help this patient but he was not happy with the treatment and aggressive in displaying it. The physician, PA, and I had to set firm boundaries with the patient and not cross them no matter how aggressive or demanding the patient was. I understood why the patient was frustrated and tried to use that understanding to show empathy. I

learned that it isn’t going to always work or go smoothly. I also learned that many factors can effect a patient, including their significant other who may be the one instigating the conflict. It was a challenging situation, but I learned and gained valuable experience from it.

COMMENTS: --, you (and attending and PA) handled this situation well, but it was a really tough one. It sounds to me as though you were likely dealing with an issue of addiction, and a wife who was enabling addictive behavior. All the empathy in the world may not be able to transform that situation, because the core assumptions that underlie relationship-based medicine have been superseded by the patient's need for chemical relief. Nevertheless, this does not mean that empathy is useless, only that it is insufficient. Boundaries, which you clearly set, can also help, but they are not a magic solution either.

The interesting question becomes what do you do when the "plan" doesn't work. Of course, it is natural to feel frustrated and let down by a patient in whom you invested such effort and attention. But realizing that the patient is in the grip of forces beyond his control (and probably so is his wife, who may be terrified of what will happen at home if this patient doesn't get his Ambien) can help calm the emotions.

This patient and his wife are suffering. The way they are expressing their suffering is highly inappropriate, but it is suffering nonetheless. There are certain ways you can help them (Trazadone) and certain ways you can't (Ambien). Being absolutely clear on this point while expressing your empathy for what they are going through may help. Not always, but this combination is your best hope. And, at least in primary care, if it doesn't work in one visit, it may work in the next. Keep your boundaries, maintain your empathy, and be hopeful.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

AOD Difficult Encounter Assignment one

"We cannot do a paracentesis on this patient. His bleeding risk is too high with an INR of 2.2" the interventional radiology fellow said. When I communicated this to the hepatology fellow, she responded "Actually, INR is not a good predictor of bleeding risk in patients with cirrhosis. Maybe your team can do it." However, my senior resident was not signed off on the procedure and did not feel comfortable performing it. Meanwhile, Mr. A was on his 4th day of hospitalization and was in pain and agony because of the ten liters of ascites that filled his abdomen. After ruling out infection, the only thing that kept him in the hospital was a therapeutic paracentesis. Mr. A desperately wanted this fluid removed but never complained or voiced his frustration. Instead, he would tell me every morning with a weak voice, "I just want to go home and play with my kids."

B, the intern on the service, and I were determined to make this patient feel better and to discharge him so that he can be with his family as he wished. After reaching out to multiple senior residents, we eventually found one who was signed off on the procedure and who agreed to help us. As the bottle started to fill, Mr. A was visibly relieved and expressed a great deal of gratitude afterwards. I reflected on this experience as I walked to my car at 9 pm that night and felt a mix of emotions. I was disappointed that Mr. A was not getting the appropriate amount of attention and care that he deserved because many physicians involved in his care wanted to avoid the possible complications of the procedure. However, I also felt an overwhelming amount of satisfaction knowing that my persistence had paid off and learned that I had to be persistent and advocate for my patients.

Another Encounter:

While on my family medicine clerkship I met a 55-year-old male patient who only spoke Spanish. Given that I know very little Spanish, I had to use a phone interpreter which definitely made this encounter a difficult one. The patient visited our clinic in order to establish care after he had lost his Kaiser insurance. It was clear to see that he was really anxious when I walked into the room as he was making phone calls, trying to make sure that things are sorted out with his insurance and the he could make Dr. X his PCP. When I spoke to the patient on that day, he told me that he wasn't taking his hypertension medication which I was quickly bothered by. However, after further discussion I found out that his hypertension has been uncontrolled for the last 5 years despite trying three different medications. "What's the point of taking medication if it doesn't work?" he said to me. After digging through his chart I found that CT of the abdomen that was done for a different medical problem. That CT scan incidentally showed that this patient had an adrenal adenoma. I thought to myself this could very well be a functional adenoma and could explain why his blood pressure has been uncontrolled. After discussing it with my attending, we decided that we would do a thorough investigation and find out what was cause this patient's uncontrollable hypertension. It was clear that he had given up on ever getting his blood pressure under control. However, I reassured him that we would do everything we can to get to the bottom of it and that we cannot leave his blood pressure like this. He was doomed for a cardiovascular and or cerebrovascular event if we didn't figure it out. As a matter of fact, his blood

pressure was 185/89 in the office and we had to send the patient to the ED given that he also had a headache and blurry vision.

Although the patient was from a different culture, I was still able to express to him how much I cared about his health. However, it was clearly more difficult to do so given the language barrier. On that day I learned to not judge patients so quickly and became more aware of how language and cultural barriers can sometimes get in the way of providing patient the best possible health. I learned that I would have to be more patient with patients of a different culture and make sure that their psychosocial needs are met.

COMMENTS: Dear --, thank you for these essays, they made me think about several different issues. In the first case, as a non-physician I'm probably insufficiently aware of the possibility of physicians refusing to do a procedure because of the risk of complications. I'm sure there is a line where the risk clearly exceeds the possible benefit; but there must also be a grey area where the physician must assume a higher level of risk in order to help the patient. In such cases, I always wonder about the surrounding factors that might influence these decisions: the confidence of the physician vs. burn-out and burden, the socioeconomic status and race of the patient, the best interest of the patient vs. the hassle/stress to the doctor. These decisions must necessarily have an element of subjectivity in them, but I would hope that the comfort and wellbeing of the patient factor in heavily. In reading your account, I felt both relief and pride that you and your intern went the extra mile for this patient when others seemed more interested in avoiding a potentially challenging procedure. Especially when the patient is too sick and weak to advocate for themselves, the responsibility of the physician is to be that patient's voice. Indeed you and that intern should feel very gratified that you had the courage and commitment to provide this service to your patient.

Your second example is instructive as well. I admired how, even when the patient had given up, you did not, employing Sherlock Holmsian determination to find an answer if possible to the patient's HBP. In my view, you drew exactly the right conclusions. It is SO easy to form judgments about people about whom we know so little: Doesn't care about his health; is nonadherent etc. Language and cultural differences complicate our understanding of others, often in profound ways. With this patient, he had lost hope because of medication failure, despite having a life-threatening medical condition. Instead of judging him, you mobilized your intellectual curiosity as well as your emotional intelligence to go beyond the surface to help the patient. Patience, curiosity, and compassion go a long way toward making even frustrating or distressing encounters satisfying and interesting experiences.

CURRAN ART OF DOCTORING 2019.20 ASSIGN 1 DIFFICULT ENCOUNTER

A difficult encounter that I had with a patient and her family started as the first stroke code we had while I was on my Peds Neuro service after a 16-year-old girl presented with 2 days of increasing right facial droop and left sided body weakness. We all rushed to the ED, and her
MRI showed that it was unlikely stroke, but more likely multiple sclerosis. Talking to the patient and her family, it was clear that she had a developmental delay. The next day, I sat down with her and her mom and took a more thorough history. The girl was very quiet about her history and her mom told me of her long-standing diagnosis of bipolar disorder. Her main symptoms of bipolar were that "lies all the time" and "hallucinated." Since visual hallucinations are less common, but possible, symptoms of multiple sclerosis, I asked about that and her mom stated that she told her teacher that a family member had raped her, but that the patient had been seen by a doctor and "that couldn't have happened." The teacher had reported it to CPS, and the mother now felt that it was a symptom of her psychiatric disease. The mom continued to tell me how often the child "makes up things that were wrong with her." When interviewing the patient alone, she remained quiet and did not open up to me about her history.

My heart broke for this patient, who based on her brain imaging could likely have been having periodic symptoms of MS for months if not years. Her mom, who admittedly had multiple psychiatric diagnoses of her own including paranoia, approached the child with skepticism, immediately dismissing both her symptom as well as her admission of rape as not plausible. As a medical student, in the moment, I knew that the best I could do was to take a history – since the child was hospitalized, we had time for further discussions with the family and I wanted to make sure that I didn't say anything wrong. The team and I agreed: many of her previous "made up" symptoms were likely early sign of multiple sclerosis (though this does not preclude her from having a psychiatric illness), and also it was unlikely that she had a single hallucination of rape. While these were important for the patient and her family relationships, they were bigger picture problems outside of the current hospitalization (especially since we confirmed the assault had been investigated by CPS). Thus, we did not change our management at all, but in every conversation with the mom and her daughter reiterated that all of her current symptoms are very consistent with the exact location of her brain lesions and we are very confident that none of them are being "made up." Additionally, we repeated that she likely had previous symptoms from her same disease, and they may have not been visible to others. We recommended that she change psychiatrists "to one that may be familiar with MS," hoping that the child may find a more supportive ear.

I still don't know if we did everything that we could to help this relationship, though that is notably difficult in a course of 2-3 days hospitalization, but hopefully we help set her on a path towards the right changes. I learned to trust my gut about what is going on with a patient and the family, and always believe the patient. It sounds as though therapists and doctors backed up mom in many of these situations, and that likely not only did irreparable harm to the relationship between the patient and her mother, but the lack of support from medical professional likely forever broke the girl's trust in the medical community.

COMMENTS: --, one thing I particularly like about your role here is your unswerving advocacy for your patient. This was in the face of mother's skepticism, as well as reported skepticism from the members of the medical community. By digging, your team was able to come up with a diagnosis that was a better fit for her symptoms, and offered an alternative and much less manipulative explanation for many of her claims. Yet you managed to do this while not alienating the mom, who was the patient's caregiver and would remain so. In fact, while I agree with you that only so much can be accomplished in a short hospital stay, at least you provided both mom and daughter with a more accurate way of interpreting her symptoms in a less blaming way.

I also might be a little more hopeful about your patient's future interactions with the medical community. True, she encountered physicians who disbelieved and pathologized her. But she also met you and your team, and you truly did help her, as well as respected her, believed her, and took her seriously. This positive experience may make a difference in her next medical encounter. And by the way, one of the best things you did was encourage mom to find a new psychiatrist for her daughter, one who at least could be on her side.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

His wrinkled sun-beaten skin, mud-stained clothing and ruddy fingernails hinted to hishistory of homelessness. His sunken cheeks, thin knobby knees and his skin and hair of the identicalbronzy hue werephysical manifestationsof the "12 daily pints of vodka" he told me he drank since age 12. His eyes darted around the trauma bay as his torso writhed and he repeatedly and frantically gasped for air."I can't breathe, I can't breathe" he chanted hysterically.His other words were unintelligible, a finding that correlated with his urine toxicology screening positive for methamphetamines. The nurse hastily wrapped a pulse oximetry monitor around his index finger, as he became more agitated– flailing and guppy breathing. His legs were cold to the touchyet beads of sweat rolled off the tip of his nose. The pulse oximeter flashed a 56% reading before he yanked it off. 10 seconds later, it was back on, this time on his toe. Again,he ripped it off. Back on again, now on his earlobe, as he batted around blindlyabove his head. The red alarm flashed 62%, then 50% then 32%. The resident announced evidence of fluid in his lungs on the EFAST ultrasound.Moments later,Dr. M.,the poised attending, strolled into the trauma bay. With his white coat, perfectly pressed and buttoned, he worea composed smile like he was taking a Sunday afternoon stroll in the park. He paused, glanced at the monitors then at the patient. With what felt like the biggest understatement of the century,he announced, "Looks like you are having some trouble breathing, Sir." He continued in a matter-of-fact tone, "We can help you with that, we will get you breathing better with some medicines." A bipap machine was strapped over the patient's skull andthemask covered his mouth.He writhed and yanked atthe mask. Despite attempts of redirection and explanation,he removed the breathing machine, announcing "I ...gasp...don't...gasp...need...gasp...no ...gasp...F**ing...gasp...mask...gasp...." The bedside X-ray showed bilateral lung white out from likely CHF fluid overload and an aspiration pneumonia. He was cajoled into wearing a nonrebreather oxygen mask, that only moderately increased his oxygen saturation to 75%. He was deteriorating fast.No IVs could bestarted due to hisagitation and 30+ years of IV drug-use that blew all his veins.After what felt like hours of watching our patient thrash around like a freshly caught trout on the dock, the decision to intubate the patient to stabilize his breathing was made. Dr. M. put his hand on the patient's shoulder, in a perhaps feigned attempt at human connection, and informed our patient that he would need a breathing tube to save his life. Things went from bad to worse. The patient violently shook his head in horror, breathed even faster, as his oxygen saturation nose-dived and his heart rate jumped to 150, 170, 190. "No tube, no tube, no tube!" The whole room was taken aback by his strong reaction to potentially lifesaving treatment. Was he, in his intoxicated and frantic state-of-mind,ableand allowedto make such a radical decision? Dr. M. shook off his surprise and reevaluated the situation. In an attempt to establish the patient's capacity to make such a decision, he asked a series of questions all of which the patient answered correctly: "Sir, what is your name?" ... "And where are youright now." ... "Yes, UC IrvineHospital." "And what city are you in?" .... "Yes, you are correct, Orange." ..."What year is it." ... "Why yes, it is 2019." "And sir, do you understand that you could die tonight if we do not put the tube in." The patient nodded vigorously before returning to "No tube, no tube, just let me die." It seemed clear to all in the room that the patient did not want to be intubated, even if it cost him his life. The question that hung in the minds of many in the room, was, even if he is alert and oriented and understands the consequences of declining care right now, can he make this decision while**

intoxicated? But Dr. M. was confident and informed nursing staff and respiratory therapists that we would not be intubating the patient –per the patient's wishes. Soon after this decision, myself and the physicians left the room, but not before Dr. M told the patient, "If you change your mind, and want to breathe better let us know." I was left wondering, how is the patient going to alert us of his changed decision and would he even remember what decision he had made? I hung back in hesitation and asked the nurse, "so now what happens?" The nurse explained that he would likely die of respiratory distress, possibly in the ED, and there was nothing more to be done. When he codes, we will do CPR, but not intubate him and he will die.I checked in on him every 20 minutes throughout the rest of my shift but went home before his status changed. I do not know what happened to him -if he changed his mind or even had the opportunity to. I was left with questions about the ethics of the situation and my eyes were opened to how quickly difficult ethical situations must be weighed and acted on. It was as clear to me as anyone else in the room that night that our patient did not want to be intubated, but the decision not to left me questioning how much his mental state was clouded by substances and potential underlying psychiatric disease.

COMMENTS: Dear --, your essay reminds me what a fine writer you are. The vividness and specificity of your language made me feel I was right beside you (and relieved I wasn't!). This was such a hard case, and even reading about it I was very uncomfortable. I think you raise excellent questions about capacity due to positive meth screen. I also wonder about depression influencing a possible desire to die (suicide by lack of doctor intervention!). Of course, patients have a right to refuse treatment, but despite the patient being oriented to time and place, I was not convinced he had capacity to make a life-threatening decision. I am not a doctor, so I don't know whether it mattered, but it also bothered me that his ox-sat was so fluctuating, which also might have affected his decision-making capacity.

As the medical student, you have limited options. The attending, perhaps correctly, judged that the patient DID have capacity and was making an informed choice (the striking contrast between the patient's and doctor's appearance and demeanor served to underline, however, the vast gulf separating these two individuals, and the worry that the powerful physician, literally holding the patient's life in his hands, might struggle to perceive the many factors impinging on this patient's understanding that he could die without intubation). Although you might have pursued the attending's decision with him, I know the ED is not conducive to long conversations between students and attendings.

I'm also wondering about a Psych consult. Although everything always seem emergent in the ED, the patient was left for a time just hanging out waiting to die. Could Psych have popped in? Of course, this would not be your call, but once again the "confident, poised, composed" attending probably felt this was not necessary.

So you took the steps that were available to you - regularly checking on the patient until you left. I wonder if he was conscious, if you were able to interact with him, and if he persisted in refusing treatment. It would have been nice if there was a DNR in his chart, but somehow I suspect this sort of documentation did not exist.

Like you, I remain dissatisfied that this patient was, in effect, left to die. I worry that if he were a wealthy individual from Newport Beach this decision would not have been made so confidently. Like you, I worry about his mental state as someone struggling with great difficulty in his life. It is indeed hard to accept that you do not know what happened ultimately. We hope for a happy end to the story, but in this case we are not even certain what that happy outcome might look like.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

My Favorite Difficult PatientOne of the most memorable "difficult" patients for me was someone I encountered on the first day of my internal medicine rotation. He was a patient with rhabdomyosarcoma, which had metastasized to his vertebral column, and I first heard about him when the senior resident was assigning us our patients to follow. He suggested that none of the students should follow this patient because he was too complicated to deal with. Despite not carrying this patient myself, he became the most memorable and important patient during my eight weeks on internal medicine.I came to find out during rounds that the patient was too large for the hospital MRI machine, and he was scheduled to be scanned at the zoo. This had taken some time to arrange, and now at the last minute, the patient was refusing to go, which had infuriated the medicine team. When we saw him during rounds, he was extremely agitated and angry at UCI. It turned out that the reason he was refusing to go was that the neurosurgeon had given him a different explanation for his symptoms, and he didn't think the MRI was necessary. He was furious at our institution because our teams could not agree about what the plan for his care was, and he threatened to have his lawyers "sue UCI into a parking lot."Once we had conversed with the other team and come up with a unified plan, the patient was in a considerably better mood and agreed to be scanned on the larger machine. After this, he became one of my favorite patients of all time. Every day during rounds, he invited us as students to learn as much as possible about his case. He also had an amazing sense of humor and cracked so many jokes that were often crying with laughter when we left his room each day. I looked forward to seeing him every day and was heartbroken when he was put on palliative care. When he was transferred to the ICU, I went and visited him to learn more about his past and even spend time with his family while he was unconscious.I will never forget the dramatic transformation of that patient from one of the scariest, angriest patients I have encountered into the sweetest, funniest, and ultimately saddest cases of my time as a student. It was an important lesson to me about how we can never judge a patient on their behavior during what is often the most trying experience of their life. Beyond that, it also showed me how important a unified plan is for a patient who is scared and confused about their future, and I will always try my best to do this with any care which I provide in my future as a physician.

COMMENTS: --, although I was very sorry to read that this patient was placed on palliative care, there were many aspects of your story that moved me deeply and actually buoyed my heart. First, although this was a patient you were "warned against," you still reached out to him. Second, despite his not being your patient, you listened to him to better understand the root of his anger - and you discovered that, as is often the case, the confusing contradictory messages of the different teams involved in his care had really upset him (and no wonder). Third, once the teams coordinated and came up with a single plan, the patient's behavior improved dramatically, and you were able to help him access his generous, humorous nature even in these very difficult circumstances. Fourth, you honored your connection with this man that only existed human to human (i.e., not institutionally, as in he was not officially your patient) in a profound way, following him to the ICU and reaching out to his family when he could no longer communicate.

I agree that a unified treatment plan can alleviate a lot of patient anxiety and fear, and avoid much conflict. However, the most important lesson I take away is how the commitment of one individual to another can transcend anger and resentment, and can reveal untold resources of sweetness, humor, and goodness - in both patient and doctor. I wish this patient had not died. But I am happy he died connected to you - as a patient (even if unofficially) and as a teacher.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

On medicine, I had a patient who would not stop bleeding from his mouth. He had presented for bleeding after a wisdom tooth extraction three weeks prior in the setting of a supratherapeutic INR due to a history of a mechanical mitral valve after endocardidits, currently on warfarin. Despite transfusions, the application of vasoconstrictive medications, sutures placed by ENT, and placing a sitter with the patient, the patient continued to bleed. Though it would seem that the bleeding had been controlled for a couple of hours, it would then resume and was difficult to control again. He was in the hospital for over a week and the case was frustrating for my team.

It turned out that there were multiple things happening that were at odds with the treatment plan. The alternating vasoconstricting medications were meant to be placed on the site of bleeding for an hour each but instead were being removed after 10 minutes when the initial gauze would be soaked with blood. Also, it was determined that the patient was going into the bathroom and either aggressively swishing water around his mouth or reaching into his mouth and removing his clots himself. These things were only determined when, out of frustration, I went into the patient's room and spoke with the nurse, the sitter, and the patient together. He was discharged the next day after these facts came to light and appropriate changes were made in his treatment.

It was reminder that though we are busy doing many things in the team room, there are answers that we can't find from labs or imaging, and instead, can only be found out by speaking with the team and observing the patient firsthand

COMMENTS: I am very appreciative of your conclusion, as it supports the notion that some things must be discovered through direct human interaction. It was fascinating to see how all of these specialized, technical solutions, instead of advancing the patient welfare as intended, were implemented in an uncoordinated manner that ending up having the opposite effect.

I also noted that it was the dedicated medical student who took the time to investigate, and then to put all the pieces together into a coherent whole. In the increasingly complex world of medicine, making sure all the awesome individual pieces actually fit is an essential consideration, yet one that is too often ignored. Each specialty is in its lane and usually content to stay there. Thank goodness we have observant, caring, and curious medical students who are scrupulous and compassionate detectives as well!

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I am currently on an anesthesia away rotation and I recently experienced a difficult encounter with an attending while in the operating room. The day started at 6 am and the first thing my resident did was warn me...this attending was not always the easiest to get along with but if we just do our jobs it should be a good day. Less than an hour later, the patient is wheeled into the room and I started attaching the monitors to the patient like I was instructed to. I had attached monitors onto patients many times at both UCI and the institution I was visiting, so I felt confident that I had done it successfully. Minutes later the attending is yelling at me in the operating room, with the surgeons, residents, and scrub nurses just watching us. He is asking seemingly rhetorical questions like "what is going on here?" and "since when do we attach monitors like this?" All I can do is mumble "sorry"...I have no clue what he was looking for. He then proceeds to get upset that I am not answering his questions so he repeatedly asks "since when do we attach monitors like this" and I come up with "I'm sorry this is how we do it at UCI- I thought it would be the same here". That was apparently a good enough answer to end this awkward situation and he readjusted the monitors himself. I was totally embarrassed and quite upset at him for treating me the way he did in front of the entire OR staff. Once the case started and things calmed down the attending came up to me and explained why he reacted the way he did and how he expects things to be done going forward. I again explained that I had not been taught any other way, and the resident even chimed in to say he didn't direct me as to how this particular attending likes things done. We put the situation behind us, and I was gearing up for what I thought would be a long, painful day. However, as the day went on, when I was asked to do something I would clarify how they want it done, and then do it properly. The attending noticed that I had taken to asking more questions and learning his style and he told me I was improving. We ended up having a pretty good day, and throughout my rotation I went on to work this attending a couple more times and we had a good time together. This situation taught me to never be afraid to ask questions, or to ask for clarification and direction in doing things, especially in unfamiliar settings. This is definitely a lesson I will carry with me into residency and beyond.

COMMENTS: Dear --, of course this attending's behavior in yelling at you in front of the OR staff was highly inappropriate, intimidating, and unproductive. It sounds as though on reflection he felt somewhat embarrassed by his unprofessional behavior; while he did not directly apologize to you (all physicians should take a course in learning how to say two simple words - I'm sorry!), he offered you an explanation, which I think was his best effort to acknowledge its inappropriateness.

In this case, you ended up doing most of the reparative work, but you did it very well. You made overt that different settings may have different procedures; and you were proactive and explicit in making sure in each situation that you would conform to their expectations. Since you were the learner, I think the attending and resident could have done a better job in preparing you for your ER tasks. That being said, being able to assertively yet respectfully ask questions to clarify expectations and procedures is a highly useful skill.

It is a sign of maturity and professionalism to be able to ask, even after a highly uncomfortable encounter, what can I learn from what just happened? What can I usefully carry forward? It doesn't

mean that the other parties involved have much to learn as well, but you can't control whether they master the lessons they've been offered. You do have a choice about what you take away and here you extracted all the benefit you could from an unfairly punitive encounter.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I met Ms. B during my third year OB/Gyn rotation. She was diagnosed with metastatic vulvar cancer, which had progressed nearly beyond repair due lack of medical care secondary to her uncontrolled schizophrenia. She was lost to follow up for several years, stuck perpetually in her own delusions. When her daughter became her caretaker and legal medical decision maker, she insisted that the patient be admitted to the hospital for stabilization and treatment. As a result of her schizophrenia, she experienced audio-visual hallucinations and was often not oriented to time or place. She frequently tried to harm the nurses and cursed at staff that entered her room. On most occasions, she demanded to be taken to Home Depot in order to complete her furniture shopping. She was a quintessential "difficult patient."

As part of her work-up, Ms. B needed a colonoscopy to evaluate the extent of her disease. However, the preparation proved to be challenging. In order to prepare for her procedure, she needed to drink liters of GoLytely; a difficult task even for healthy patients. In order to make sure this happened, the residents kindly asked the medical students to sit at the patient's bedside and encourage her to take sips of her GoLytlely as frequently as possible. During my shift, the patient cursed and spat as I tried to encourage her to take small sips. It was frustrating and tedious work. However, I tried to put myself in her shoes and understand how scared and disoriented she must have been. Rather than internalizing my frustration, I attempted to remain patient and remember that this procedure was in the best interest of the patient. Although this situation was extreme in many regards, I learned that when patients lash out, it is often a result of fear and not a personal attack.

COMMENTS: Hi --, I like that you wrote about this patient because she is not easy to like. The situations that interest me are those where empathy is not automatic or easy. How do we keep a check on our impatience and frustration? How do we relate to a patient who is living in an alternate universe and sees you (if she sees you at all) as an enemy.

There are no magic answers to transform this difficult event into a magical encounter. The patient is not suddenly going to lose her schizophrenia; her cancer is not going to disappear; and most importantly her fear and complete disorientation are not going to evaporate. So you have little to build on with the patient. In these circumstances, you did exactly the right thing as far as I can see - you worked on yourself. You acknowledged your (very understandable) emotions of frustration and tedium. BUT you persisted, you stayed the course. You imagined (as best you were able) the world from this patient's very troubled perspective. You reminded yourself that, although the patient could not see it, you were acting in her best interest.

And critically, you reframed her anger and agression as manifestations of fear. I could not agree with you more - although this patient was an extreme example of a frustrating patient, it is quite true that fear often masquerades as anger in all sorts of patients; and when we can penetrate to that core, it is usually easier to connect with the patient and help them with their fears.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

One of the most memorable difficult encounters I had during my third year rotations involved seeing a patient in the outpatient clinic. I was assigned to see a patient for a post-operative visit and to make sure her pain and symptoms were controlled at home. I knocked on the door, entered the room, said hello and sat on the stool and began to log myself into the EMR. The first thing the patient had said to me was, "Do you speak English?" In that moment, I felt a sudden urge of anger, and I usually don't find myself an angry person. I kindly responded "Yes, how can I help you today?" But as the patient began to describe how she had been feeling at home, I couldn't quiet the voices in my head thinking, "Did she really say that?" I felt extremely judged, ridiculed, and frustrated. However, I calmly recollected myself and went on to proceed forward with the visit. The encounter ended in a way I would have never predicted.

After I was able to simply let go of the frustration from our initial greeting, I gave her my undivided attention to what brought her into the clinic. Surprisingly, she has been recovering very poorly, and the surgery has impacted her quality of life. She was adjusting to life using a colostomy bag and had explained the frustrations of the bag leaking and embarrassment she had been going through in public. Understandably, she recounted multiple stories and I ended up pulling the stool closer to her and simply lending an ear. By the end she was in tears, but felt very reassured that she could confide her problems with me. The encounter had made me realize that not everyone is going to be happy when they walk through the clinic door and they could be very much going through difficult times at home. Those frustrations could then be displaced onto the provider, and we have to recognize that and move on to treat the patient with full empathy and care.

COMMENTS: I respect that you were able to handle the patient's initial racist comment with at least external calm; and even more impressed that you could genuinely listen, focus on the patient's misery, and empathize. Of course, the patient's remark shows the pervasive fear of the perceived "other" (based perhaps on appearance, name or some other superficial "cue") that has always been an evil undercurrent in this country and in recent years has burst forth in virulent and unchecked form. It isn't easy to find a rebuttal that doesn't sound defensive or escalating. In this case, simply letting it go and listening deeply to the suffering of the patient worked wonders. Your attention and caring helped win your patient's trust and move her beyond her biases and prejudices.

I would encourage you to remember that, while this approach worked well and you were able to let go of the sense of judgment and ridicule you experienced, you do have other options. Health care professionals sometimes underestimate the emotional and psychological toll that being the target of such microaggressions can take. So, for example, In a respectful but clear manner, it is not inappropriate to set limits on a patient's (or colleague's or superior's) racist language. This is not so much because you hope to change the person's prejudices, but to convey to them that certain behavior is not acceptable in the clinic or hospital setting.

It is also true that sometimes people are not truly racist, but momentarily speak from fear or ignorance. In such situations, once they begin to see you as another human being, and a highly knowledgeable and expert one at that, their perceptions often shift. As you say, this may have been the case with this particular patient, who may have simply been simply venting her own feelings of shame and frustration, displacing them onto you. Each situation is different, and you must judege what level of response is required. Just keep in mind that boundaries can be an essential part of the therapeutic relationship.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

Of the difficult encounters I have had thus far, there is one that stands out above the rest. A particularly kind, cordial and accomplished patient came to the ER with a long standing history of epigastric/abdominal pain. She had been in and out of the same hospital for months; work-ups included
Ultrasound, stress tests, ekgs, blood work but a CT scan of the abdomen was never ordered. It baffled me that her severe pain was unrelenting even throughout her admission stay and was discharged with the same continuous pain 2 weeks prior to presentation to the ER with the diagnosis of pancreatitis. In my limited experience, these constellation of subacute symptoms of severe pain, continuous nausea and vomiting with inability to tolerate PO sounded and smelled like a worst case scenario diagnosis of pancreatic cancer. Sure enough, the diagnosis was suspected by CT and discovered it had metastasized.

This was by far the worst news I had to deliver to a patient. She was devastated by the news. I was devastated by the systemic failure of a full admission without a complete work up. It is unlikely her management would have changed and I am sure she will not get proper care, yet I perseverate on the notion that her answers could and should have been answered sooner. Upon discussion with an attending, he agreed and commented that the variable that led him to suspect pancreatic cancer was how nice she was. Apparently there seems to be a correlation of kindness and cancer of which I feel uncomfortable with.

COMMENTS: What a sad situation, and what an infuriating one too. While you are probably right that an earlier diagnosis would not have made a significant difference, the patient deserve the best possible care and the best chance at saving her life. That she did not receive this is a disgraceful mark on our healthcare system and the physicians who cared for her.

I'm not really sure what your attending meant by a correlation between niceness and pancreatic cancer. I'm pretty sure there is no research evidence substantiating this claim. Did he mean that because she was not annoying, he took her symptoms more seriously and decided to do a more thorough work-up? This too would be a shocking revelation. Of course care should not be determined by the personalities of patients, but it's often the case that "niceness" and its opposite do influence all sorts of intangibles in healthcare.

You note that "this was by far the worst news" you've had to deliver. I can only imagine how hard this must have been. I wonder what you were feeling - distress for the patient, anger (and maybe some collective guilt) toward the system which had let down this patient so terribly, helplessness, sadness. I hope you were able to mobilize those feelings to support the patient and help her understand this devastating diagnosis. It is one of the great challenges of medicine that in such dreadful circumstances, the physician must somehow transcend (not set aside) his or her own feelings and focus on the patient's needs. This being the case, it's important to remember to find a way to process and even grieve - and perhaps this essay provided a kind of outlet.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

It was my second week of wards, and I had just begun to grasp the intricacies of patient-doctor or for me, patient-medical student relationship. This foundation was quickly renovated when I met X*. X was here for a shortness of breath exacerbation. He had developed systemic lupus erythematosus when he was in his late 20's and has been battling it since. A 35-year-old 6'2 heavily built white male with a track record for felonies and misdemeanors did not appreciate having a disease that he described "was supposed to be for women." X was not complying with his medications. Since I worked in the emergency room prior to medical school, this was not what made the encounter difficult. X was hopeless. Not in the sense that he could not be helped, but in the sense that he had lost hope. Using both cocaine and heroin as well as anything else he could get a hold of, he was torpedoing towards his own morbidity. At first, my initial warning as well as that of the doctors went unnoticed and slightly aggravating to X. In fact, frequently residents would truncate their time spent with him and advise medical students to do the same due to his aggressive personality. Luckily a course in the philosophy of free will taken during undergrad prepared me slightly for this situation. I decided toget to the root of X's addiction in a nonjudgmental and explorative way. After understanding that he began at the age of 13 and that his main guilt for continuing was his 10-year-old brother it became a much more intimate conversation. I decided to no longer pester him with any attempts of requesting his abstinence from drugs andinstead doubled down on the importance of his medication including a thorough probing and filling for his understanding of maintenance medications. I had to reiterate how many people cared about him, including myself, but importantly his mother and brother. Due to my growing bond with the patient, the team asked if I wanted to discharge the patient.I took the responsibility with the help of a nurse knowing that if anyone would give our patient the last motivational pageantry it should be someone that knows him most intimately. When the time came however, I decided not to rehash it as his little brother was present in the room. However, to my surprise the patient himself brought it up, reassuring me that it would still be extremely difficult for him to quit but that he would again visit rehab and take his prescribed medications. He even presented to me a plan on a weekly basis as he tried to reapply for jobs and get his life back together. I was shocked but more so I was proud and inspiried by X.

Comments: What an awesome encounter (which, by the way, shows the value of exposure to humanities in encouraging critical thinking and independent choice! :-)). I am very glad indeed that you did not follow residents' recommendations to avoid this patient! instead, you practiced curiosity and nonjudgmentalness simply to try to really "see" this patient and perhaps discover how you could help him.

I was also impressed that you decided not to hound him to stop using, but instead highlighted how adherence to medical regimen could actually improve his quality of life. Sometimes indirection is the best route. When patients feel scolded and judged, they tend to retreat into defensiveness and hostility.

Over the course of your conversations, you also learned what was important to him - his little brother. To me, it is highly significant that although you decided not to revisit the details of his situation in order to protect the brother, your patient by contrast made a declaration of commitment IN FRONT OF him. This speaks to the patient's level of motivation and his intention to follow through. You and I both know that the odds of this patient entering and succeeding in rehab and adhering to his drug protocol are not high. But I think the way you handled his care gave him the best chance possible. Your interactions with the patient helped him restore hope and take concrete steps to improve his situation. This is what being a good physician looks like.

AOD 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

I recently had to deal with an extremely angry patient who was upset at the medical team for delaying his diagnosis and subsequent surgery. Although I had nothing to do with the clinical workup and management up until that point, he nonetheless was angry at me. This experience demonstrated that sometimes you may not have anything to do with the reasons why patients are upset or angry, but you may nonetheless have to deal with the consequences. At first, I felt defensive and wanted to say that I had nothing to do with his care and this is the first time I was meeting him. But after further consideration, I realized that taking ownership of the healthcare he had received so far was a better option, since as a medical student, you are part of the team and not an individual representative.

I explained that I was sorry for his delay in care, and he still was angry and told me he preferred to speak with a real doctor and not a medical student. That was completely understandable, but again, considering his point of view made me understand why he was so angry. I eventually kept rounding on the patient with the rest of the team, and slowly but surely, he began to warm up and be more polite. He was happy with the care he was receiving, and eventually became less agitated.

This experience taught me how important it is to be patient, considerate, and realize that some things will be out of your control, but how you react and handle these events can influence the outcomes.

Comment: I agree, it is often the case that a patient's anger has less to do with you personally, and more to do with feelings of helplessness and fear that the medical condition engenders. In some ways, this makes the patient harder to deal with, because it's easy to think "I'm only trying to help. Why is the patient behaving so badly?"

I think you chose the wiser and better course. Putting yourself in the patient's shoes does not necessarily excuse the patient's behavior, but it makes it more understandable. Once we understand the "why," we can more effectively address the anger. As you discovered, sometimes simply staying "present" with a patient and refusing to be "chased away" by their bad behavior sends the message that you will not abandon them and are committed to their wellbeing. Often, when patients realize this, they become less frightened, feel less alone, and are more willing to cooperate with their own treatment.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

In Anesthesiology, patient interaction is mostly limited to the pre-operative and post-operative period. These interactions, although brief, are extremely vital as the patient is at their most vulnerable and scared state. What might seem like a regular procedure to us can be the patient's first time ever going through surgery and they are depending on our guidance and reassurance. From the moment you greet them in the pre-op area to the last few seconds before they drift into unconsciousness, it is our responsibility to make them feel as safe as possible. I recall a difficult patient-attending encounter during one of my Anesthesiology Sub-internships right before patient induction. The patient was a middle-aged female going through a standard common procedure in which the case was running late on time due to the previous case.

For reasons I do not entirely recall, Versed was not given before rolling the patient back to the OR. Everything was going along smoothly until right after I placed the oxygen mask on her face. She immediately looked uneasy and looked like she wanted to say something. I slightly tilted the mask, so I can hear what she wanted to say, and she let me know that she just remembered that she doesn't do well with oxygen masks because of a bad childhood experience. Her vitals at this time were objectively still within normal limits, however subjectively I can tell how uncomfortable she was beginning to be, so I stopped pre-oxygenating her and just let the mask rest on the side of her face out of her field of vision. Since this case was already running late to begin with, I could feel the pressure of all of the staff and how they wanted me to quickly preoxygenate, so I could start intubating the patient. The anesthesiology attending began to wonder what was taking so long as well and urged me to hurry up. At this point, I had a difficult situation on my hands. I could have put the mask on anyways despite what the patient told me and hoped that after the induction medications went in she would be okay. But, there was also no way of knowing if she would end up getting a panic attack if I proceeded that way. Instead, despite the pressure from the rest of the team, I decided to hold off on pre-oxygenating and waited it out with her. Since I was the only one who heard what she said, I explained to the attending and the rest of the team member the situation and how I felt it was necessary to stop until she calmed down.

After what I told them – the team agreed with me and we ended up letting her hold the mask herself. We actually ended up pushing propofol without preoxygenating and the case went by smoothly. After the case, the circulating nurse came up to me and told me how appreciative she was that I didn't force the mask on the patient. She mentioned that most medical students would just preoxygenate anyways and disregard the patient's concerns to appease the attending or resident. Through this experience, I learned that above everything else, patient safety and comfort comes first. We might learn all these things that are beneficial, such as preoxygenating a patient before starting induction, but all rules have exceptions that should be bent and tailored towards the patient in front of you. While ignoring some concerns might be easier and seem more "efficient", I learned the importance of speaking up for myself even when you're at odds. Even though my decision prolonged the starting time for the case and everyone was pressuring me to hurry up, I knew that it was the right decision and ultimately what's best for the patient.

COMMENTS: I very much agree with your insight that anesthesiologists' communications are critical, and that the ability to form a trusting connection with patients is particularly important at this vulnerable time. It rests in the anesthesiologist's hands whether the patient goes into surgery feeling safe or anxious.

I really admire how you handled this situation (I can't comment medically not being a physician but it seems that your choice was medically as well as psychologically sound). It takes a great deal of courage for a medical student to stand with the patient, initially against the entire medical team, especially when time constraints are pressing. The easy choice is simply to go along with what your higher-ups are expecting. Instead, you chose to support your patient's desires because you could see that they stemmed from real trauma, and might lead to a panic attack.

Your careful listening to the patient produced the subsequent realization that avoiding the oxygen mask was an emotionally hyper-charged issue for her. You trusted your judgment that honoring her request "mattered," and that the best way to care for this patient in these circumstances was not to simply proceed. It also made sense for you to share your thinking with the rest of the team. This enabled them to evaluate your actions from a different and more supportive perspective.

Finally, I think your conclusion is spot-on. You are absolutely correct that medical protocols are there for a reason. But the reason we still have doctors and not robots is that you can judge the particulars of a given situation and determine whether a modification is necessary, just as you did in this case. You say it very well: patient care "should be bent and tailored towards the patient in front of you." This is the deepest meaning of personalized medicine.

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When I was on medicine at the VA, we had a patient that we were consulted on in the SICU. We were asked to assess if he was appropriate for hospice. He was 78, seemingly uroseptic with an impacted stone and his family was at the bedside. His two adult children, a daughter and son, and their spouses had made it clear to the surgical team that the man led a sad depressed life, and that he repeatedly said things like, "just let me die" and "I don't want to live like this. Just let me die" for months preceding this incident. So now that he was acutely ill, they felt they did not want to proceed with surgery. The resident was starting to question the patient's living conditions (which were unsafe, he lived with a 98 year old lady in unkempt conditions) as well as the ethics of letting him go without treatment at this venture, the patient's son began to become upset. "How can you judge us??" he said, becoming louder, verging on irate. "You don't know what it's like for us, for him. This is our decision." After some discussion, the medical and the surgical team discussed the matter further privately and decided to transfer the patient to medicine to coordinate transfer to hospice. However, as Murphy's Law would have it, and as old men at the VA seem to do, the patient started to improve on his own without any treatment. And then we were stuck with this man who was in acute pain, depressed and miserable from the pain of being arthritic and bedridden, and extremely unhappy with his care. To make matters worse, he had acutely had a change in his speech pattern without sign of stroke giving concern for dementia to this new team. I as a med student was sent to do a MOCA to assess his mentation do determine if we could have him make his own medical decisions regarding hospice vs surgery vs medical management. Upon talking to him, but not after he demanded that I feed him the rest of his pie, I learned that he was as sharp as a tack; although he would say things like "Me no want to do this test right now but me will do it if you want. This no way to treat army man. Me army man. Me no belong here," he got a relatively high MOCA score. This likely would have been perfect if his essential tremor and poor eyesight did not bias the exam. When I went to go tell my chief that I thought he was likely able to make his own medical decisions (and that the team sent to assess his capacity did not properly do so as they only heard him speak and get angry and made a biased conclusion before really assessing capacity), but I was told that his MOCA was not passing (2 points below normal) despite all of my aforementioned explanations. When I reiterated to my team with the attending present in front of the patient and we all witnessed this patient's mental capacity, and I saw that we all recognized it although it was acknowledged. The patient stated that he wanted to leave the hospital and go home, but he was denied. This was because there was no safe place for him to go, but there are so many issues I have with this patient's care that it still bothers me. They let that man stay labeled as demented, the nurses ignored him, they made him feel imprisoned in the hospital due to a lack of ability to find a suitable disposition plan, the list goes on. In hindsight, I would have involved his family more, but they were already stretched very thin. I think the team could have explored this more, as well as medical management. All around it

was a bad situation, but I wish more could have been done for the patient in the time that he was stuck in the hospital with us.**was a bad situation, but I wish more could have been done for the patient in the time that he was stuck in the hospital with us.**

COMMENTS: --, you are so right, this was a very frustrating case on so many levels. I wonder if at any point there was discussion of an ethics consult. These can be very helpful in bringing a different perspective to bear on the situation.

There were several aspects that troubled me. Perhaps the worst was tje determination of lack of capacity, despite compelling evidence to the contrary. I would have thought that such discrepancies would have triggered a formal psych assessment. In my view, you did the right thing by adevocating for the patient, as it sounded as though the team's conclusions may have been influenced by their frustration with the patient and their selective focus on his most aggrative behaviors.

Although it sounds as though both patient and family members expressed a desire for him to be discharged to home, it was unclear to me whether the family was motivated by the best interests of the patient or by their own distress at the overwhelming nature of his situation. As you state, the living situation itself was unsafe, so that was not a desirable outcome; but it was impossible to find an alternative. Transfer to hospice sounded like it would be the best way, if patient and family could understand this as a way of providing care, safety, and support, relieving some of the patient's suffering and some of the family's burden.

I commend your feelings of unease, because we SHOULD feel uncomfortable in distressing situations. I am not sure there were any truly good options, but by clarifying goals of care with patient and family in a nonjudgmental way, perhaps a solution such as hospice could have offered a way forward. Your thoughts to continue dialogue with the family and to have the team more engaged may indeed have helped move everyone toward a better resolution; and it seems to me you did what you could as a medical student to encourage the team to take a more thoughtful approach to the care of this patient. As you know, your power as a medical student is pretty limited, and I respect the way your wrestled with this situation.

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In psychiatry, “difficult” patient occur almost every day. In medical school, our clinical experiences in psychiatry are primarily in the setting of acute inpatient psychiatry, where we see the sickest individuals. Despite how hostile, aggressive, high, or uncooperative patients may be, I recognize that they are truly suffering, and I believe that I truly do want to help them.

During my away rotation at a prestigious institution, my first patient was a fifty-six-year-old male with suspected autism spectrum disorder, bipolar disorder, and a history of traumatic brain injury domiciled with his eighty-year-old mother. His therapist had just “fired” him because of medication non-adherence, and he was brought to the ED for manic behavior.

During the initial interview, he made some inappropriate statements, such as asking me (and other female staff) out to coffee, and I quickly and firmly set professional boundaries. Some patients become hypersexual during episodes of mania, and so I reassured myself that this would not happen again. However, day after day, as the symptoms of mania began to simmer down, I continued to be on the receiving end of hypersexual, inappropriate statements despite all my efforts at setting boundaries. The patient’s ex-therapist and mother explained to me that because of his mental illness, he is unable to understand social cues, but he means well. Yet I found myself dreading these encounters. I also felt as if I could not express this discomfort to the residents or attendings supervising me because it could be interpreted as a sign of weakness or incompetence during my away rotation, which is essentially a three-week long interview.

By the last week, I set my mind to helping my patient discharge from the hospital. His mania had improved, and he had little to benefit from inpatient hospitalization. Interesting, his neuropsychiatric symptoms were suggestive of frontotemporal dementia, a disorder in which patients display personality changes with increased aggression, impulsivity, and hypersexual behaviors. A formal diagnosis would require imaging findings demonstrate atrophy of the frontal and temporal lobes in addition to the clinical findings, and if he had this diagnosis, his treatment course would require intervention from Neurology rather than Psychiatry. Because I had developed relatively good rapport with this patient, I was able to coach him through getting the MRI of his brain, and eventually, through the family meeting and the remainder of the discharge process.

Reflecting on this experience, I still don’t know if there was a better way
To handle it. I continue to question whether I should have confided in someone or requested that a male colleague follow the patient instead. At the same time, I

feel selfish that I lacked the compassion and the strength to set aside my own feelings of discomfort during my encounters with this patient. Through this experience, I learned that reframing difficult patient encounters by focusing on the bigger picture is a potential strategy for making the best of the “difficult” patient.

COMMENTS: --, for me, one of the most powerful aspects of your essay is your awareness that when you see beyond the hostility and aggressiveness of some patients to their fundamental suffering, you are able to remain compassionate and able to assist them. Then, with great personal honesty, you disclose a case in which you truly struggled with maintaining compassion in the face of a patient's hypersexuality and highly inappropriate behavior toward you.

All I can say is that boundaries and compassion are not incompatible. In my view, you did absolutely the right thing in trying to establish limits with this patient. Although I fully understand the constraints imposed by a 3 week "audition," when your own efforts were not effective, I wish you'd been able to approach your residents or attendings (I recognize how hard this would be in an unfamiliar institution where you had no prior relationships). It is certainly no sign of weakness to ask for help - indeed, in my eyes it is an act of courage. (I do acknowledge that others, with more retrograde perspectives, might interpret it differently). We cannot feel compassionate if we do not feel safe, and so that must always be the first priority.

For what it's worth, I don't think we can - or should - set aside our feelings. Instead, we can learn from them. I hope that what you learned is that you deserve to structure situations in a way that makes you feel as safe and comfortable as possible. Indeed, I find it remarkable that, despite all the personal stress this patient was causing you, you thought conscientiously about his situation, continued to work toward discharge, and even came up with an alternative diagnosis that might better explain his symptoms.

You are quite right that "reframing" is a great strategy. When we see inappropriate patient behavior as evidence of suffering, we become less reactive and more present. However, compassion does not mean that we should ignore interactions that may be harmful to us either psychologically or physically. I hope that in future situations you will always remember that putting your patient first does not mean putting yourself last. You may discover that the more comfortable you feel in the relationship you develop with the patient, the better care you will be able to provide.

Dealing with a “Difficult” Patient I saw a patient on my psychiatry rotation, who could be classified as “difficult.” She had a previous diagnosis of depression with psychotic features and was brought to the emergency department by her daughter due to complete lack of self-care for a couple of days. The patient had stopped eating, stopped showering, and stopped leaving her house. Her depressive symptoms were exacerbated by the recent death of her husband. When the patient was admitted to the inpatient psychiatric ward, there was some suspicion for catatonia and I was tasked with performing a catatonia evaluation on the patient. I had heard from the nurses that patient was “unpleasant”. When I asked the patient if I could perform the test for catatonia, the patient immediately stated, “why would I do that? I don’t need to that.” She then repeatedly stated, “I’m fine.” I explained to the patient that her daughter was worried about her because she had not eaten and the patient continued to state, “I’m fine. I don’t need any help.” Unsuccessful in getting the patient to cooperate, the resident I was working with suggested that I try again the next day. The following day, the patient continued to be uncooperative and was refusing all medications. However, later that day, a judge mandated that the patient take anti-depressants because she was not competent to make that decision on her own. I continued to speak the patient every day for a week, and I noticed small changes in her behavior over the course of the week. The patient started to eat a little more, and she was more interactive with other patients in the psychiatric ward. However, I was sad that her attitude toward me had not changed. Everyday, I would ask her how she felt, and she would state, “I don’t need to talk to you. You can leave now.” Then, two days before the patient was set to go home, I went to talk to her, fully expecting her to have the same attitude toward me that she had always had. I was surprised to see that she was sitting up with a smile on her face, she answered all my questions and even thanked me at the end. She told me that the attending physician had said that she could go home in two days, if she continued to make progress.Looking back on my numerous encounters with this patient, I can definitely say she was one of the more “difficult” patients I have cared for. The difficulty did not stem from the complexity of her medical issues, but rather that I felt that I was not making any progress in my relationship with her. Everyday, I would dread having to talk to her. I would see all my other patients first and then finally, approach her room. However, seeing her attitude immediately change when she was informed that she could leave the inpatient psychiatric ward made me realize that her “difficult” attitude was not due to me or the nurses or the numerous doctors she saw everyday. She was depressed and upset with her situation. She was not acting like her true self. Thus, I am proud that I persevered in talking to her everyday and was part of the care team that helped her improve and helped her daughter feel comfortable in taking her home.

COMMENTS: What particularly impressed me about this experience was your commitment to the patient, your willingness to "stay" a very unpleasant course. Day after day, despite the patient's rejection, you returned to the bedside and tried to connect. I completely agree that depression is the explanatory factor in the patient's hostility. After treatment, and with the news that she would soon be discharged, she became more friendly and appreciative. Yet even in the absence of depression, some patients will test their physician, in a way "daring" them to abandon them by inflicting bad behavior on the doctor. It takes great courage and great empathy not to react to these jabs, and instead return day after day, offering support and comfort. It is indeed difficult not to see progress, as you note. There is an ancient saying from the Bhagavad Gita that says "Be not attached to the fruits

of your actions." In other words, it's great when we get the outcome we desire, but from a moral perspective, what matters most is that we do the right thing, regardless of results. In this case, you were rewarded by witnessing a transformation in your patient, exactly what you hoped for. But I would have respected your actions, even if the patient's depression had been refractory, and her behavior had persisted resistant and uncooperative. Regardless, when we remember that patients' problematic behavior is usually driven by fear, pain, or mental illness, it helps us not to take it personally but to persist in extending a helping hand.

ART OF DOCTORING 2019-20 ASSIGN 1 DIFFICULT ENCOUNTER

During my internal medicine rotation, our team encountered a difficult situation involving a family member of a patient. Our patient, an 85-year-old male, had severe congestive heart failure and his family was discussing putting him on hospice care at a nursing home. His elderly wife felt that she could no longer care for him adequately at home, especially since she was the only one living in the house with him. While most of their children sympathized with her, the oldest son objected to this idea, stating that in their culture it would be morally wrong to do so. He would angrily barge into the patient's room, yelling at the rest of the family stating that "they would all go to hell."Our team was shocked and unsure of how to delicately navigate this situation. Although some unsavory words were exchanged between the family members, we clearly all wanted what was best for the patient. While we did not fully comprehend the cultural and religious background of the situation, we did our best to calmly understand everyone's viewpoint through multiple family meetings. After listening to everyone's opinions, as well as the pros and cons of each option, we eventually reached a compromise. Though the oldest son definitely wasn't happy, our team was able to prevent the situation from escalating beyond what was necessary to craft a safe plan for the patient. From this experience, I learned that in order to do right by the patient, it is important to keep one's own emotions in check. It would've been easy to antagonize the oldest son for the way he treated his mother, but blaming and vilifying him would have only made it more difficult to reach a common solution.

COMMENTS: Your essay contains an excellent insight. I agree, we naturally have our initial reactions to various complex clinical situations, and it is easy to want to ally ourselves with those whom we deem to be right, or good, or likable or whatever. Indeed, at some point we may find ourselves taking a side. But before that happens, it is crucial, as you indicate, to understand all points of view nonjudgmentally and respectfully. Of course, that is not the same as agreeing with all sides. But just listening deeply can provide valuable insights about how to continue dialogue with everyone involved in the most constructive way possible.

In this case, the obvious "problem" family member is this eldest son. He opposes the rest of the family, he yells and threatens them with hell, and he wants his elderly mother to continue to somehow continue meeting all the physical and emotional needs of a desperately ill husband. Yet, as you know doubt discovered, he has his perspective. He probably feels that it is cruel to place his father in hospice, a form of abandonment of a respected parent. Perhaps he feels guilty about some perceived deficits in his relationship with his father. In any case, by understanding better what is motivating him, it can illuminate a path forward. By attributing the best possible motives to someone (love, protection toward his father) we can sometimes put the other at ease, and make it easier to find common ground.

You and the team worked very hard to de-escalate the situation, rather than the opposite, by patiently continuing dialogue and seeking understanding rather than condemnation. As a result,

while resolution was not perfect, it was a step in the right direction, and importantly safeguarded the wellbeing of patient (and likely his wife) as much as possible. I commend you and the team for persevering with open minds and hearts.

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When you have the title of “doctor,” people naturally turn to you for the answer. If the patient wants a diet, page the doctor. If the patient’s pressure starts bottoming out, page the doctor. If the patient is a hard stick, page the doctor (even though the doctor likely has even less experience placing an IV than the much more qualified nurse). There is a certain sense of duty that is beholden upon the title, and more often than not, that responsibility can be overwhelming. I would like to expand more on a particularly difficult encounter I had in which I was unable to provide the answers a patient desperately desired.

On my Inpatient Medicine rotation, I was tasked with admitting a 59-year-old male presenting for sudden onset weakness and back pain, now febrile. His blood cultures were positive for MSSA and he was started on antibiotics. The patient, KA, had a complicated medical history with primary progressive multiple sclerosis (MS) complicated by left-sided weakness and currently on immunosuppressant treatment, chronic back pain and a history of back surgery. Neurology was consulted, and they stated it was probably progression of his MS and signed off. Infectious Disease was consulted, and they stated we would treat his bacteremia, but it was unlikely we would determine the cause for his infection - it was probably due to the plates placed for his back surgery, despite being lower down than where his pain presented. CTs and MRIs came back negative for any seeding of the infection into his spine. As I visited KA each day, I grew concerned that despite his white count going down and his lack of fever secondary to the antibiotics, his physical activity continued to decline.
1 week after his admission, I entered his room and found that he was unable to move his lower legs, and he felt as if Zeus were throwing bolts of lightning down to his toes. We decided on getting a repeat MRI, despite the fact that he had a clean one when he was first admitted. It took 18 hours for a STAT MRI to be completed. For 18 hours, we waited, tense and baffled by the patient and his presentation. For 18 hours, I watched the patient sit in pain, exasperation, and helplessness. I would walk up several times to his room on the 6thfloor, apologizing for the delay, letting him and his wife know that we truly wished the process was faster, but we hoped the imaging would give us an answer. When it was finally completed, our fears were realized, as the MRI now revealed an epidural abscess, exactly where he had been complaining of back pain when he had been first admitted. He was rushed to the OR where the abscess was drained, however, the damage had been done.

There were so many questions the patient had that I was unable to answer. Where did he get the MSSA infection? Was it because he touched a door handle at his mother’s nursing home? How did the infection get to his spine? Should he not have gone to the dentist a week ago to get a crown placement? Why couldn’t the MRI be done faster? Would he ever be able to walk again? Each day I entered the room, I felt nervous and frustrated, because I fervently wished I knew the answers. I was unsatisfied with the recommendations and workup of the specialists and dismayed to watch the deterioration of my patient.

However, despite the negative outcome, I am grateful for the positives that shone through. Just being there for the patient and his wife helped them to cope. Explaining to them everything that I did know helped them feel acknowledged. Being vigilant about any new changes in his condition and reporting those findings immediately showed that their care was being prioritized. Understanding medicine for many will usually be clear as mud, so learning how to be the appropriate filter or sifter of information is something that I recognize as instrumental in mastering when it comes to approaching a difficult situation. As doctors, we will most likely run into hundreds of difficult encounters where we are unable to give a satisfying explanation to our patients. But, I found that if I acknowledged their concerns, showed that I was invested in their case, and explained thoroughly what I did know, even though I could not be the bringer of all answers, I would have gained their trust and respect during a difficult time, which is equally if not more valuable in the long-term.

COMMENTS: --, this is a truly wonderful essay, especially the two concluding paragraphs. Outstanding insights! You get what it means to be a physician! One role is the "bringer of answers," and of course that is what both patients and doctors want. But what if the doctor doesn't know the answers, or doesn't yet know them? As you astutely and compassionately discern, a vital role for the physician still exists. A patient without answers is doubly alone and frightened. Hearing different explanations and different suggestions from different teams can be disconcerting and confusing. What the physician can provide in this situation is support, updates, empathy, and honesty about limitations. As you did, the physician can also diligently continue to pursue answers and information. Patients want to know that they are not forgotten, that their care matters to their doctors, and that they are not suffering alone. They are often befuddled by their condition, and then a skillful "interpreter" can shed much-needed light. I think the attitudes and behavior you demonstrated not only win trust and respect from patients, but makes the burdens they must carry easier to bear.

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Very recently I had both a difficult patient and a difficult family member, making for a difficult clinical experience. I was on my away rotation in New York City in inpatient psychiatry and I admitted a 52-year-old woman with traumatic brain injury (TBI) for hostile behavior/danger to others. The patient had broken her third television after acting on her anger towards one of the characters in the TV show she liked to watch. If it had just been a matter of her breaking her property, I would have let it go, but unfortunately for everyone involved, during her rage she attacked one of her home health aids and so 9-11 was called, who then brought her to the unit.

Personally, I have never had a good outcome with a TBI patient. If they have damage to their frontal lobe many will have absolutely no impulse control sometimes leading to extremely volatile and mercurial personalities. This results in seemingly random bursts of anger that cannot be reasoned with. There's no filter for emotional responses. On top of the extremely difficult behavior to manage, TBI is relatively uncurable and there's really nothing you can do for most of these patients. My patient fit all those boxes, except she was also a type 1 diabetic, loved soda, and would become infuriated if we took away any source of sugar. However, her sugar levels were skyrocketing so we had to keep soda away from her for her own good. She attacked multiple staff members, other patients, would scream at everyone around her. No one liked being around her. In addition, her sister, who was completely fed up with caring for her, and despite not having TBI, was almost equally nasty towards staff and would both demand that we find placement for the patient but also would repeatedly tell us, "I'm done with her. She's your problem."

So overall a difficult situation, and I'd be lying if I said it had a better outcome than any previous TBI case I'd seen. However, I did have a wonderful opportunity to practice my motivational interviewing. No matter how malicious the patient was to me, I let it all wash over me and constantly expressed alliance with her and praise for her efforts, and sure enough she responded excellently. Even if she started the conversation with, "No! I don't wanna talk to you" within minutes she'd be shaking my hand. This case was an important lesson that often times in psychiatry, or medicine in general, you need to check your pride at the door, take nothing personally, and do/say whatever you need to in order to get your patient the care they need.

COMMENTS: --, this sounds incredibly frustrating. I don't know much about TBI beyond what you've already stated, and agree it is a very aggravating situation in terms of managing patient outbursts. Although it helps a little to remind oneself, this is not the patient's fault, she can't control her behavior, it is still a frustrating situation!

So if you can't change the patient, who can you change - you! Your MI strategy, although not yielding perfect results, is still your best bet. If you can figure out a way to stay calm, avoid escalation, pair with the patient, and reinforce her for any positive behavior, there is a chance she will respond. This was clearly an instance where this was not about you, but about a lack of impulse control and filter that was beyond the patient to deal with. Knowing this can help us maintain a good attitude. If the physician thinks of him/herself as the servant of the patient, it encourages the humble attitude needed to absorb

the slings and arrows patients sometimes direct our way. I always try to remind myself that the patient is dealing with a lot of suffering, confusion, and fear. This is not a justification for bad behavior, but it does increase understanding and therefore empathy.Great job with a very challenging patient.