ART OF DOCTORING ASSIGNMENT 3 COMMENTS 2008
AOD ASSIGNMENT #3 COMMENTS 2008

--, thanks for this thought-provoking essay and its highly creative format. Your use of point-of-view writing really forced me to enter into this situation in a more than academic way. I identified immediately with the daughter who couldn't even go to the bathroom in case the all-powerful doctors arrived; only to be unceremoniously booted out once they showed up! It might not have seemed like a lot from your vantage point, but thank goodness someone at least bothered to send this poor woman a sympathetic glance.

What to do, what to do? At the bottom of the totem pole, you can't easily change attending (or hospital) policy. I actually think your ideas make a great deal of sense. As you suggest, if you talked to your attending, you might learn the reasons s/he has for systematically asking family members to leave the room. They may not be very good reasons (more efficient, family members distract the rounding, ask silly questions), but they are his/her reasons. It's also possible that there is a more legitimate explanation (which you and I in our combined wisdom haven't been able to think of :-)). In any event, with this knowledge, you could make an informed decision on your own. Does such a practice have merit? If not, then you have a choice point. Is there something you can do to alter the physician's practice? Possibly, and if so you need to decide if this would be worth it in terms of the potential personal cost to you (just because you can do something, doesn't mean you should, right? Each situation deserves thought). If you think that intervention is low yield at that level, there are still other options. Perhaps discussing the situation with the residents might reveal their discomfort, and a consensus that rounds should not be conducted in this manner. Perhaps all that is required is a personal vow that, if you think this policy is misguided, it is something that you will make every effort to avoid as a resident; and certainly as an attending.

Finally, perhaps this is a situation in need of some metta: metta for the patient, who must have been so helpless and frightened when her daughter left; metta for the daughter, who must have felt she failed her mother when the mother needed her most; metta for the residents, who were too cynical or too afraid or too indifferent to speak up on behalf of those so powerless they had no voice; metta for the attending, who must be deeply frightened and/or resentful of the patients and families he is sworn to care for; and finally, metta for the medical student, who must bear witness to all the shortcomings of the system which she has committed herself to.

Best, Dr. Shapiro

Hi --. Great essay, although a troubling event. First, let me say on a content level, it is hard to see how accepting the patient's desire to leave was "bad judgment." From what you describe, the patient was not at the time a danger to himself or others; and seemed to

have the capacity to care for himself. It would have been great if there were a transitional environment for the patient; and in fact, you identified a very reasonable one. I think you learned not to take for granted that patients will automatically do what is in their best interests (in this case, go to the program); and I believe talking to the patient and stressing the value of follow-up is an excellent take-home message. However, I think it also likely that, despite your most persuasive efforts, the patient was sufficiently unstable that he still would not have gone.

And that brings us to the final and most important lesson you learned. “There are limits to what you can do for your patients.” How true that is! That doesn’t mean that you shouldn’t try your utmost to do the right thing for each patient; it doesn’t mean that you should be angry at patients who don’t accept your counsel; it doesn’t mean that you should become cynical or bitter that medicine doesn’t work like a neat algorithm. It does mean that, when things go right, you should be very grateful :-). It does mean that when things don’t work out, despite your best efforts, you learn to forgive yourself, and your patient; hope/pray for a good outcome anyway; and be willing to try again with your next patient.

Thanks for this thoughtful sharing, --. Dr. Shapiro

--, thanks for this honest and perceptive essay. This is a great example that I’m sure many of your fellow students would resonate to. As someone who likes to just put my head down, and hates conflict, I still have to agree completely with your conclusions. Most of the time (nothing is always true, right?) it is definitely better to get problems out in the open, because that gives you at least a chance of working toward resolution (not that that always happens, either!). To me, the key is how you go about “getting them out in the open.” When someone is very defensive and doesn’t appear too concerned about your welfare, sometimes a Columbo approach (do you know that tv character from the 90s?) can work. “Help me understand your approach to teaching.” Sometimes expressing appreciation for the person’s approach (ridiculous as that sounds) can open a dialogue: “I really have learned a lot from all the responsibility you’ve been giving me.” Having a very specific request can help (not “please stop being such a jerk” but “I’d really like to discuss my observations about this patient with you”). Sometimes, as you suggest, going up the chain of command to a superior is effective, especially if you can go as a group of disgruntled students, rather than one “troublemaker.” Bottom line, as you well know, there is no fail-safe method for transforming an unprofessional, exploitive person into a humane, caring educator. But by practicing different strategies in these difficult situations, you will inevitably develop greater skill, and over time have greater success in resolving them as best as possible. Dr. Shapiro

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Brilliant, --. You get it completely. Dr. X sounds like an amazing physician, an outstanding role model, and someone who well deserves ongoing accolades from

students and patients. And I'm sure she gets a lot. And I'm also sure she didn't "deserve" this family member's wrath. But, as we've discussed, an important lesson in good doctoring is "don't take it personally." This fabulous doctor was in the wrong place, at the wrong time – or maybe not, because she had the skill to absorb the father's rage and recognize, as you do now, that it came from a deep well of helplessness, grief, frustration, loss of control etc. Of course, it is not "fair" that Dr. X was the recipient of this assault. But she apparently didn't worry about that too much; and it sounds like she could take care of herself – and her patient and her patient's father! It is natural that you wanted to defend her, just like you often want to defend a patient. But usually the wisest strategy is to see where *everyone* in the situation is coming from; then you have the best shot at charting the wisest course. Great insight, very well-expressed. Dr. Shapiro P.S. And I hope you've shared with Dr. X just how much you admire her!

Outstanding reflection, --! Your hypothetical dialogue is really superb. Of course, things don't usually go quite as smoothly in real life as in 20-20 hindsight. Nevertheless, you became aware of the core issue underlying the son's concern: He was actually ready to let his father go, but he didn't want him to SUFFER! Ah, common ground. Amazingly enough, neither did his physicians. The steps you went through were wonderful: 1) a little empathy for the son's suffering over the last few days 2) a little clarification of misunderstandings and your true intention 3) finding common ground around minimizing suffering 4) and (since it's hypothetical :-)) being rewarded by winning the son's trust and confidence. I am so glad in real life that things went similar to your imagined dialogue. I would also say that many, many times in medicine, if at first you don't succeed, try again. You are often given a second chance; and by not running away from the feeling that things didn't go exactly right the first time around, you can return to remedy the situation. Very well done. Dr. Shapiro

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Dear --, this is a painful situation, but one well worth reflecting on. One issue had to do with how to sensitively yet honestly tell a child he has bone cancer and will lose his leg. That in itself is a huge challenge. But on top of this is the dilemma of how to dialogue with a mom who absolutely refuses to have you tell her child his diagnosis. This is very, very tough.

--, I liked the way you were able to identify so well where this kid's mom was coming from; and to respect her strength in trying to protect her son the only way she knew how, even while you strongly (and in my mind appropriately) disagreed with her.

I think you've identified the ethical issues very well. The boy is twelve. Over years of treatment; through an amputation, will he not figure out more or less what is wrong? Yet, if it is supposed to be a secret, who will he be able to talk to about

what's going on? The mom's strategy is understandable, but not realistic; and may actually end up harming her son, if he finds out accidentally, and feels he was deceived and lied to.

Your ideas for approaching/negotiating/dialoguing with the mom are superb. Your patient does need to know what is happening to him, but exactly how and when could benefit a lot from mom's input. Your idea of involving Child Life with mom to explore different ways of breaking the diagnosis is a very good one. I also thought it was a great approach to ask the mom to listen to what you wanted to say; and have her give you feedback. "That would scare my son." "My son would like it if you said that." Another idea is to address the issue, but "at a slant." Rather than power struggling over "tell," "don't tell," maybe take a little "time out" to find out more about her son. What is he like? Is he a strong kid? Has he ever dealt with tough situations before? Is he the kind of kid who likes secrets being kept about him? Once you and the mom can get on the same side – i.e., what is the best way to protect this kid and keep him safe? – then the discussion could move forward. Mom would feel she had a little more control over this horrible thing that was happening to her son. Then hopefully she and the team, including Child Life, could work together to figure out how to talk with her son.

Finally, I really respected your capacity for maintaining your liking for this mom, even though she was not being "cooperative." You saw past her intimidating aura to a mom fighting for her child. Excellent insights all around! Dr. Shapiro

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--, what a powerfully written story. I was deeply affected by your final lines. I am almost 60 years old and both my parents are still alive. My husband lost his mom and dad 15 and 10 years ago; and I have often reflected on how these two realities have shaped us. I agree with your friend – there is a way that you become an adult when your parents are gone that no other life experience can produce.

Your essay conveys very well the demanding, confrontive, aggressive nature of this family, particularly the son. By the end of the first paragraph, your reader probably loathes them as much as you did. Then, after the bait, the switch. In one brief glimpse through a crack in the door, the son is humanized; and you recognize that sometimes the only way a family has of expressing their love is circling the wagons and fighting against all comers – including those who have come to help – until the bitter end.

Hope the video conferencing thing worked. I saw -- with his laptop going when I arrived. However, hope to see you in person soon. Best, Dr. Shapiro

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-- you did so well in reflecting on this truly appalling interaction. Not that it's my place, but I'm really proud of you! To be honest, it's hard to imagine a first-rotation 3rd year student on her first rotation – and surgery yet! - speaking up about much of anything (except maybe, "so which one is the protractor?"). What I admire is how quickly you realized that your own professionalism was also involved; and that you always have the option to intervene. It's not necessarily the right choice, or the only choice, but it should always be considered seriously. Even as a lowly medical student, you may be able to exercise enough "power" or influence to tip the situation in a different and more positive direction. I respect that you are now ready to try!

To me, one of the worst aspects of what happened is that much of the back-and-forth occurred in front of the patient (I guess there is more than one reason to be thankful for anesthesia. Still, I'm enough of a biopsychosocial type to be concerned that the patient was exposed to that level of acrimony even *under* anesthesia!). The whole scene is a sobering illustration of what can happen when the attention gets channeled away from the patient to the egos of the health care professionals supposed to be caring for the patient.

--, it makes me happy to think of you in the future as a resident in your own right speaking up to say, "Hey this is just wrong. Let's work it out a different way." The nurse anesthetist (and even the resident) must have been napping during the lecture on professionalism :-). Best, Dr. Shapiro

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ZZZZs, --. Not much sleep on SICU?! You present an interesting dilemma. Patients in teaching hospitals tend to either a) not understand the health care system very well, and often don't really grasp the difference between medical students, interns, residents etc.; so aren't upset by the teaching atmosphere because they don't understand it b) be kind of shocked and scared when they realize that "students" and folks just out of medical school have their lives in their hands c) understand upsides and downsides of teaching hospitals, and have consciously chosen this location for hospitalization (I've actually met a few patients like that!). As you point out, it's puzzling that the patient's daughter worked at UCI, presumably knew a lot about how a teaching hospital worked, and yet was distressed by the involvement of a medical student in her mom's care.

Nevertheless, you handled the situation well. Often, as you probably have realized, people in the hospital setting are just barely hanging on to their sanity (and I don't mean just the doctors :-)). Patients are confronting serious illness; family members are having to witness the suffering and perhaps dying of their loved ones. It is a difficult atmosphere, and people are often not at their best. This daughter was trying to take some action to protect her mom, even though her choice was inappropriate and irrelevant. Rather than power struggle, you deferred to her wishes; and then proceeded to build trust; and actually show her the value of your involvement with her mother's care. Good work, --, in managing both your own

understandable emotions and not giving up on this family member. Best, Dr. Shapiro

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--, this is indeed a heartbreaking story for so many reasons. Most tragically, as you rightly identify, is that a smart young man full of promise will have a very different – and probably much less good – life after this event. In such cases, we are still just not that good at putting the pieces back together (although for an inspiring account of a woman with severe bipolar disorder [including psychotic features] who nevertheless has made a brilliant career for herself as a researcher of [naturally] bipolar disorder, read An Unquiet Mind, by Kay Jamison). I also imagine it must have been terribly frustrating to have worked hard to connect with this patient, and help him feel safe and understood, even in a severely psychotic state; only to have it rapidly dissolve when you stepped out of the room for a moment. Of course, with a patient in a hypomanic phase, this outcome may not have been avoidable. But it does suggest that even in very difficult circumstances, talking, listening, and being willing to enter the world of the patient can be a powerful alternative to force.

I am very intrigued – and respectful – that instead of being discouraged by this experience, you have developed a "compassionate curiosity" for interacting with psychotic/schizophrenic individuals. I have great admiration for your ability and interest in risking moving closer to these people, rather than running away or dismissing them. By the way, I too am glad that, although you were open to sharing your patient's world, you hung on to your pen. Good boundary setting! Best, Dr. Shapiro

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--, great example of a "difficult situation," although a painful one to read about, and I am sure much more painful to experience as the student, and even more so as the patient. Such a cascade of disappointment and disillusionment! You know, just because someone isn't an addict doesn't mean they have lost all claim to their humanity. As I am sure you are well aware, not every problem can, or should, be solved by another diagnosis and another consult. In this case, two caring medical students were able to support each other enough to do the right thing – apologize for the callousness of the attending and team, learn the patient's story, and validate the normalcy of her desire (whether or not it was reasonable medically, it is quite understandable from a commonsensical standpoint). Another anti-lesson learned here is that if you are mean enough to patients, you can chase them away! How sad that this young woman felt so rejected and neglected that she left AMA. This is very rarely a desirable outcome, although some doctors act as though it is.

By the way, your poetic description of the attending is chilling in its imagery of her porcelain face and voice of shifting grains. That conveyed so effectively her total lack of empathy and emotional imperturbability.

Thanks for sharing, --, and I'm glad this type of experience has been much more the exception than the rule in your training! Best, Dr. Shapiro

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--, thank you for sharing this troubling incident. And as a non-physician, thank you for such a lucid explanation of the medical issue involved. I imagine you have excellent skills in translating complex medical into understandable language for patients and family members.

As far as the shouting match is concerned, you put your finger on by far the most upsetting part. It is clear from your description that the resident simply misunderstood the purpose of the intervention being performed. As you point out, it is natural to feel defensive, but as you also realize, defending yourself is not the most important thing when others' lives and wellbeing are at stake. You put it very well – you may naturally feel defensive, but "allowing" yourself to act on this feeling, fuel it by constructing specious arguments means you have put yourself at the center – where the patient is supposed to be. It is this aspect, not so much the mistake itself, that seems especially problematic. This is a resident whose default mode is highly unprofessional and ethically unacceptable.

I agree that this incident rose to a level where some action would have been appropriate. As you correctly observe, it is not the outcome that determines the justification for action. Instead, it is up to all of us to create a system that is patient-centered, and which supports taking responsibility for errors and learning from them. I think you are well on your way to being committed to creating such a healthcare environment. Best, Dr. Shapiro

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--, I loved the title of your essay. Do you think if love were covered by Medicare, we'd give more of it? I also loved the diagnosis of chronic chest pain! Finally, I liked the fact that you became this patient's "new friend," yet also realized how the patient might be "setting you up" in case you ended up disappointing him, like all his other doctors.

It sounds like you tried very hard to figure out what was going on with this patient; did so with remarkably good grace; and kept running up against one wall after another. Your essay reminds me of the following quote by Rachel Remen: I have begun to wonder if the secret of living well is not in having all the answers but in pursuing unanswerable questions in good company." **You are asking really good questions, and you couldn't find all the answers, and I don't know them either. I did become more and more curious as I read Mr. S's story. Was he somatising? Was he terrified by all his diseases? Did he come in search of love? I wonder what you thought in the end. Of course I can't comment on the complicated medical**

condition, but sometimes a new consult and another diagnosis doesn't really answer much. I wish Medicare did cover love. But of course, that might not be the answer either; and we might just have to admit bumping into a limitation of medicine - and being human. Still, I think it counts for something that you spent some time in front of your computer just wondering. Best, Dr. Shapiro

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As always, --, even with limited computer access, you display your usual insight and sensitivity. Because of the resident's error (perhaps avoidable with greater vigilance – or perhaps not, there isn't enough information) a patient almost died and was irreparably altered. Avoidable or not, this must induce terrible feelings of guilt in the person responsible. When we look around for ways of reducing our own suffering, we can come up with some pretty strange strategies, that nevertheless have their own strange logic. For example, if nothing really matters, if people don't really matter, if everything is just kind of "annoying," then I can be nonchalant – and it makes a kind of weird sense. You're absolutely right, this resident was likely suffering from this mistake and its consequences, and had no idea how to heal herself as a physician and as a person. We can have great compassion for her; while also recognizing that, unless she develops more effective ways of coping, she will become less and less good as a doctor. Your retrospective impulse to reach out is kind, and caring, and what we all need. Don't worry, you'll have another chance; just "being there" for someone who is feeling guilt and shame will reassure them that she is not a bad person; and paradoxically will let her be able to forgive herself much better than "nonchalance" and also let her remember this mistake in the most constructive way possible. Best, Dr. Shapiro

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Hi --. I'm really sorry you had to go through this experience, it sounds pretty awful. However, I loved your last line – that you carry what happened close to you as a kind of "anti-role modeling." It is frightening that when some people get a little power, they choose to abuse it to the utmost.

I also admire that you approached the resident and tried to resolve the issue directly. Although that was not successful, you made a clear statement that you would not accept aggressive, humiliating treatment. Unfortunately, there is no way you can completely protect yourself from abusive, inappropriate behavior – in fact, there is something about the profession of medicine that seems to give a few (really a small minority) people permission to act like complete jerks. I'm glad to see you have the courage to stand up for yourself. I'm also glad that you were able to apply a tiny bit of humor to what must have been a completely unfunny situation. XTF (X's triad of flaws) will be something to look back on and – I hope – smile. Best, Dr. Shapiro

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--, thanks for sharing this incident. I have to admit, I also started to laugh when I read the resident's opening comments. Sometimes people are unbelievable. I'm very glad that you didn't simply "let go" of this experience, but used the anonymous feedback system to bring it to someone's attention. It isn't always the lowly third year student's responsibility to solve all the shortcomings of the system; but by taking some action, you make others aware of the problem who may be in a better position to intervene.

Confronting the resident directly might also have worked, although given how preoccupied she was with her own importance, it's questionable. You would definitely be on the right track to use tact and respect, while not letting her off the hook. That way, if she was completely defensive, you could still maintain a tolerable working relationship with her. In general, I always assume there is still a core humanity in every person; and with a little luck and an approach that doesn't blame and shame, there's a chance it will come out. Best, Dr. Shapiro

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--, this was a truly wonderful essay. I only wish we had been able to discuss it in class. What a complex, painful, and sad situation, but also one from which so much could be learned, if only one had the will (as you so obviously did). It is a brilliant insight that, in a way, everyone was right, or at least partially right, and that your patient both wanted to live and wanted to die. If you think about it (as you did), this is really not such a paradox, but a very natural response under extraordinarily difficult circumstances. It seems that what happened is that first the family divided into armed camps over the apparent contradictions in the patient's desires; and the medical teams simply mirrored (as opposed to trying to reconcile) the conflict. It would be a lot easier (perhaps) if life was black or white, good or bad, one way or another; but it is rarely like that. We can pretend it is, because initially it seems simpler. But as you so astutely observe, entrenched positions usually lead to continued warfare which does not benefit anyone. It is all about dialogue to find common ground and shared understanding. This isn't always possible of course but surprisingly often it is. Above all, it requires a willingness to entertain multiple realities simultaneously and to help others accept this complexity as well. It is natural to feel distressed, disoriented, or even disrespected when others express a point of view at variance with your own, especially when it involves matters of life and death. The important thing is that this should be a beginning point, not an ending point. I was really impressed, --, by your capacity to realize this. Best, Dr. Shapiro

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Hi --. Thanks for taking the time to convert this file into something I can open :-). I'm so glad you did. Even though we'd all gone through the necessary motions of having you complete AoD, it didn't feel complete until I'd actually read your essay.

Funny thing. Kind of like charting "Pt counseled re diet/exercise" versus engaging with the patient to achieve real lifestyle change. In any case, I very much appreciated your thoughts. It is so hard to know the ultimate outcomes of any action – of course, we have our statistics, but each case boils down to the individual. Coincidentally, my 87 yo mother has just completed a very demanding surgical schedule over the last 6 months involving an initial temporary heart valve replacement, a total hip replacement, and most recently a permanent valve replacement. Her adult children (including me) thought it might be best for her to go quietly into that good night. But my mom and dad were determined to pursue every option remaining. Somehow, as of now it looks as though she's made it. My point is simply that it's very hard to know; and my brother and sister and I talked at length about the fact that, once embarked on an aggressive path of treatment, we shouldn't blame ourselves, or my parents, or their doctors if things did not go well and she ended up on a ventilator, eventually dying in the hospital. Hindsight is 20/20. These are very difficult choices; and even with excellent informed consent (which happens too infrequently), it is hard to fully grasp what "adverse consequences" really mean. Ultimately, perhaps the lesson learned is not to do anything too "blithely" or unthinkingly – either "automatically" proceeding simply because something can be done; or refusing to proceed simply because of assumptions about age or other limiting factors. If this patient had recovered, as my mom has, his doctors would be the recipients of the gratitude and appreciation of the family (as her doctors are). If she had suffered a prolonged, painful death, I hope we, as the family, would have had the strength to accept that this outcome was embedded in our original decision-making. Life and death are so tough. You are very right to take this incident to heart. That is the sign of a fine doctor. All the best in the future, --. Best, Dr. Shapiro