Art of Doctoring Difficult Patient/Resident/Attending Scenario

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Dear --, thank you for your thoughtful reflection about your encounter with an intimidating attending. It's obvious to me you put a great deal of effort into understanding and learning from this difficult situation. I was especially impressed that you were able to peel back layer after layer, and ultimately identify your difficulty in accepting authority as a complicating factor.

I also found your analysis of your attitude toward authority to be insightful. I agree with you that you want to have enough humility so that you can learn from people in authority (and of course people *not* in authority); it is even true that sometimes pretty awful people can become, in some ways, our best teachers! On the other hand, sometimes those with authority abuse or misuse it, and challenging their actions may be not only in your best interest, but may also help others. As you wisely conclude, as with most emotional reactions, you want to make sure that it is well-reasoned and not reflexive; appropriate to the situation and to the goals you are pursuing.

Your observations about learning style are also interesting. People do learn differently; and people teach differently. While a little anxiety is useful in focusing attention, my own opinion is that people rarely learn well under conditions of humiliation and intimidation. They especially do not learn to *think* – at best, they are able to spew rote answers. When an attending or other instructor uses an aggressive teaching style, it's worth considering whether a conversation could help make this person more aware of the effects of his "teaching"; and whether there is room for negotiation. As you point out, this is not always possible; and then it's up to you on your own to figure out how to get the most out of a less-than-ideal situation.

Thanks for this honest introspection, --. Best, Dr. Shapiro

Hi --, thanks for your essay on a difficult two weeks with a resident. I hope I get a chance to hear your thoughts about this incident in more detail T. However, in the meantime, I wanted to let you know that I especially appreciated your insights about the hierarchical nature of medical training. It is an unfortunate (in my eyes) reality of current medical education that it is very hierarchically structured, which makes roles of "superior" (teacher)/"inferior" (student) excessively rigid and impermeable. The result, I fear, is often a loss for both teachers and learners, because horizontal communication and reflection are stifled. I do agree with you that, especially in the case of the Ob-Gyn department, approaching the clerkship director would have been both a safe and effective way of dealing with this situation. I consider it unfortunate however and a limitation of the system that it is so difficult for students to approach residents and attendings directly and share perceptions of possible problems, which in turn might well lead to possible solutions. But because it is "non-normative," I understand well that it can be personally

risky for the student; and often not that successful, because there is little systemic awareness that students have a great deal to teach us, the teachers, as well as vice-versa. Thanks for sharing this experience, --. Dr. Shapiro

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Hi --, and thanks for your assignment about a difficult resident. It is truly painful to read/hear about such encounters – and unfortunately, I hear about them often. While I agree with you that there are many motivations for going into medicine, there are (at least in theory) certain standards of professionalism that should never be violated, no matter what you're there for. Rolling your eyes, expressing exasperation and contempt for another person's suffering seems to me to fall below the minimum standard, even for a radiologist (just kidding – but there is always a human being at the other end of that film). Your feelings of indignation and distress seem quite warranted under the circumstances.

In terms of what should be said or done (if anything), I also appreciated what you wrote about a "culture of complacency." It is much easier for all concerned to look away – and sometimes, I believe, that's not wrong, if someone is basically just having a bad day. But a pattern of behavior such as you describe deserves intervention, if only because otherwise it goes unchallenged. Perhaps the medical student is not the best person to provide this feedback, which given current medical culture might well be ignored. As you suggest, filing an incident report and talking to the senior and/or attending in a way that doesn't pillory the transitional resident but does express your concerns, are both options for protesting against the ethical and humanistic shortcomings of our system. But as you also suggest, perhaps hearing from you directly, not so much in a way that demands the resident to "change behavior" or else, but simply to share what you observed and how it effected you, might also open the eyes of this person, or at least make him think for a moment.

Thank you for sharing this difficult experience. Best, Dr. Shapiro

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--, thank you for discussing this resident's awful behavior. It is so distressing to hear these anecdotes; and unfortunately yours is not unique. I think your retrospective analysis is correct. At the time, it is hard to take action, in part because you can hardly believe your eyes and ears; in part because as a lowly medical student, is it really your place to intervene? Shouldn't higher-up, more important people be doing that? Sadly, although of course the answer to the last question is yes, the answer to the first question is likely yes as well. Although as you certainly know, there are many, many compassionate, respectful doctors laboring in the trenches, there are also some who are racist, resentful, and insensitive. While there may be many explanations for these attitudes, there is no justification. In my mind, a minimum threshold has been violated. Yet medicine, a profession supposed to police itself, has a bad habit of turning away. All the steps you mention (to advocate for the devastated parents, to contact her superiors, and perhaps file an incident report) are appropriate, and necessary, under the circumstances. Without

them, this residents, and others like her, will simply go on being loose cannons and doing great damage along the way. Thanks for this cogent thinking. Best, Dr. Shapiro

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--, thank you for so honestly sharing this series of painful and humiliating incidents. This is more than an ouch, I think you said it best in your comment about sticking out a foot rather than holding out a hand. To be accused of wrongdoing and attacked (either for doing your job or for something that you were NOT doing) makes most of us feel helpless and angry. It is so hard not to be defensive and attacking in response. But, as I can see you know from your wise and insightful reprocessing of the situation, this strategy rarely is effective in defusing the situation. You have already listed many ways of responding might help you move toward a more positive resolution. I think it is important to confront these types of situations directly, once they have crossed a certain threshold (i.e., is this a battle worth fighting). Learning someone's name and offering yours *always* diffuses the interaction, even if only slightly, by making it more personal. Looking for compromises (blood pressure cuff), or even better, creative "third alternative" collaborations, is also a very good idea. Further, your awareness of setting the time and place of a conversation (after the nurse has finished his duties rather than in front of the patient) would likely be much more successful; and your approach of asking whether the nurse would like to hear your perspective (giving him a feeling of control) is a basic premise in working with difficult people. Finally, without accepting inappropriate blame (slander), you can apologize for any misunderstandings, and as you describe, calmly state your perspective and intention. Here are some additional ideas, many of which in one form or another you've already touched on:

- **Ask Difficult person's (DP) perceptions of the problem *and of you***
- **Let DP go first –** don't interrupt or defend; be patient
- **Don't counterattack (aggressive);** this just escalates the situation
- **Don't withdraw (passive);**
- **Always respond positively and with appreciation to feedback**: "Thank you for talking with me; I appreciate hearing your perspective; thanks for taking the time to let me know how you feel"
- **Avoid yes-but**
- **Clarify, paraphrase**
- **Acknowledge feelings**
- **Apologize without accepting blame** ("I'm sorry you feel that way"; "I'm sorry this situation has been so upsetting for you")
- **Avoid blaming DP**
- **Compliment DP**
- **Ask if DP wants to hear your perspective**
- **Use I statements** ("from my point of view"; "the way I see it")
- **Ask for ideas on how to resolve disagreement, move forward**
- **Be willing to negotiate**
- **Set limits if necessary, but kindly**
- **Use softening words (What do you think of this idea? Maybe… perhaps;**

bear with me a moment; I was wondering…)

- **Find common ground – goals you can both agree on**
- **Look for the person's positive intention (even if it doesn't exist!)**

--, you did an extremely thorough and complete job on reflecting on a series of uncomfortable encounters that I'm sure part of you would have preferred to forget about. However, by revisiting, you came up with insightful, wise, and effective approaches that have a higher likelihood (no guarantees!) of successfully resolving the conflict. Thanks for this excellent work! Best, Dr. Shapiro

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Hi --, thanks for your prompt completion of this final assignment. Great example of stepping up to do the right thing in a difficult situation. "Even though this was not my patient…" I think what you recognized at that moment was the obligation we have to each other, not always as doctors and patients, but as one human being to another. I was also very impressed by your insight that it was the surgeon's frustration (and perhaps ego!) that influenced his communication style. The words he used emphasized the complexity and difficulty of the situation (which would justify his withdrawal from the surgery); but the unfortunate byproduct was distress and misunderstanding in the patient's mother. As you insightfully realized, the surgeon's focus was on himself, rather than on the worried and anxious family member. Your humane and compassionate response restored this mom to her rightful place at the center of care. Nice work, Dr. -- :-); and a vital lesson in terms of always prioritizing patient and family, no matter how stressful the circumstances of the physician. Best, Dr. Shapiro

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Dear --, thank you for these reflections. In my view, you are quite right to be concerned about "John's" behavior. Lying, absenteeism, and expecting others to pick up your slack do not bode well for the future of this individual. It is likely that these behaviors represent a pattern, rather than some aberration. Even if, as you say, there was some underlying explanation for these actions, the fact that "John" was unable to address these with the appropriate supervisors while on this rotation suggests he did need intervention and help. Although it is always difficult to confront one's peers, I agree that directly interacting with your peer might have been helpful, both in terms of gaining insight and assessing the severity of the problem. Certain people do not know how – and perhaps do not want - to boundaries on themselves; the only chance they have of learning is to realize that others are paying attention to their bad behavior; and that there are negative consequences. In this regard, if a "horizontal" conversation with "John" was ineffective, it would have been an appropriate choice to bring the situation to the attention of his superiors, who might have carried more clout. In this case, there were "natural" consequences, but when there aren't sometimes we have to step up. I admire you for seeing this. Best, Dr. Shapiro

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Hi --, what an uncomfortable and awkward situation you've described! There you are, still totally struggling to find your bearings as a student-physician, and a patient's husband is hitting on you! Actually, however, I disagree slightly with your supervisor in that I think the strategies you initially employed were potentially excellent ones (they just didn't work in this particular situation!): 1) Level 1: ignoring – this sometimes is all it takes 2) Level 2: refocusing the interview – your response was perhaps a bit passive-aggressive, but the overall idea is a good one. You are setting a boundary by trying to get the patient (or spouse in this case) to buy into the main purpose of the encounter. I wonder if now you could say something similar, with equal firmness and clarity, but without the anger? 3) Level 3: This is what your supervisor suggested, i.e., explaining to the patient that boundaries between doctor and patient and there for a reason, which is to ensure that the physician provides good care to the patient 4) Level 4: This is where your supervisor cut in; and of course, sometimes this degree of forcefulness is necessary and appropriate. But in most cases of flirtatious patients, you do not need to threaten them with dismissal from the practice. By simply being clear about boundaries (and not inadvertently encouraging the flirtation by giggling or smiling, which often occurs out of awkwardness or discomfort), the patient will usually back off. Thanks for sharing this event, made all the more offensive by your vulnerability as a very junior student; and I'm glad that as you've had this experience repeated, you've developed good skills for handling it. Best, Dr. Shapiro

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--, this is an absolutely terrific example! I loved this story. Your presentation of this "difficult" patient was so vivid, even I hated her by the end of the first paragraph ☺. Then your "intervention" (really listening and clarifying) while you were removing the central line was SO WONDERFUL. And I roared with (anguished) laughter when the outcome was that the residents labeled the patient crazy and paranoid. But you caught me once again! Because just when I'd completely demonized these awful cruel residents, you let me know that one of them came from a family which had devoted its entire life to helping others by running nursing homes. You showed superb empathy all around.

My only comment is that I have a slightly different take on the outcome. I really didn't see this as an example of violating the patient's confidence, or necessarily of trying to "fix everything" (although you are certainly right that this is the omnipresent default mode of most physicians – and many of us ordinary folk as well). But in this case, you'd actually learned crucial information about the patient that shed light on her previous "difficult" behavior. Sharing this with the team to me made a lot of sense. This is not necessarily a question of fixing things in the sense that it sounded quite possible the patient would go to a nursing facility, but of being aware of her fears and helping her toward a more realistic view of what she could expect. The team's response was problematic, but given your insight into what motivated it, perhaps it would have been possible (not necessarily for you as a lowly medical student) for someone to have moved the dialogue further, to help them see the patient as you saw her – a frightened, lonely woman who feared being abandoned and "warehoused."

This was a really great essay! (The writing was really strong, btw). Best, Dr. Shapiro

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Dear --, I think one of the most frustrating things for me as someone who *teaches* communication skills is when I am trying to work through a difficult situation with someone who absolutely doesn't hear me! The best communication skills in the world only work as far as both people are willing to be influenced by them. In the case of these nurses, it seemed like you were up against a brick wall. As you are probably well aware, although motivated only by the welfare of your patient (and I so commend you for taking on the advocacy role!), you landed yourself in the middle of systemic tensions between doctors and nurses. I'm pretty certain this factor played a role as well.

The only idea I have for you is the following: If you have repeated yourself a few times, paraphrased the other person and acknowledged their perspective, you can say, "Do I hear your concerns?" (Person says yes – begrudgingly ☺). Then you say, "You know, I don't think you're quite hearing what I'm saying. Would you mind just letting me know what you think my idea is, so that we're both on the same page?' Doesn't always work either, but worth a try ☺. Another approach (although by no means better, just different) is to engage in joint problem-solving, so the members of the team feel like *part* of the team. Example: "Hi nurse." "Hi (suspiciously)." "Have you noticed pt. X says the only thing he wants is uninterrupted sleep?... Yeah, you're right, that's something that's really impossible to provide a patient… You are so right, this isn't a hotel!... But do you have any thoughts about how we might try to accommodate the poor kid?"

I'm trying to be vaguely humorous, but you see where I'm going. Thanks for sharing, Dr. Shapiro

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"I've found that if I could stratify a patient population as one that is particularly difficult to work with, it would be the drug-seeking patients." You and every resident I've ever met! This is the supreme challenge in medicine – how to set clear boundaries with a patient seeking narcotics while still conveying a sense of concern and *not* intentionally or unintentionally expressing dislike, contempt etc. Pretty tall order. However, although it is certainly blunted by addiction, the primary tool you have to work with is the therapeutic relationship.

In fact, as I'm sure you know, there are an awful lot of patients who fall into the category you describe – patients with "real" documented pain who are also drug-seeking. The appropriate management of chronic pain requires considerable expertise, and even empathic surgeons (ha-ha) often get it wrong (assigning a 3rd yr med student to "deal" is probably a good indication they are not on the right track). I very much like what you say about "shared responsibility." To me as a layperson, it seems a rather arbitrary line to say, here are addictive drugs for pain; but then when the patient comes back addicted, to avoid acknowledging the obvious linkage. I also agree with you that honesty is crucial. As Dr.

X observed so eloquently during the session on difficult interactions, it usually helps to name the elephant in the room, whether it is addiction and drug-seeking, or death and dying, or some other stigmatized subject. “Naming” the problem conveys to the patient that you are not afraid to address it directly; that there is no point in trying to manipulate you; and establishing this level of honesty (however frail) is the first step toward changing the paradigm of “drug-seeking” between doctor and patient. Sadly, you are quite right that often addiction trumps empathy, caring, the therapeutic contract, and everything that we know about human relationships. Still, you have the best chance of working with the patient if you proceed as you outlined. I’m glad to hear of your successful efforts on your pain management rotation. As drug addiction is a pervasive problem, I expect you will encounter this issue throughout your career; and I hope your skills continue to evolve in working with this difficult but very much in-need population. Sounds like you are off to a very good start! Best, Dr. Shapiro

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Hi --, thank you very much for your difficult interaction essay. So, sadly, I guess you’re human like the rest of us (. I am imagining how frustrating it would be to take extra time to persuade the patient to consent to the procedure; then to come back again to elicit his fears, reassure him, only to have him agree and then back out; then to wait for his wife to arrive, in the hopes that she might succeed; and meanwhile the clock is ticking, and a long day is turning into a long night. I might have felt that I was wasting my time on an unappreciative, uncooperative patient who was really making my already hard life difficult.

What struck me forcibly is how quickly you recovered your emotional equilibrium after going down a path of frustration, helplessness, and stalemate. All it took was the wife’s expression of gratitude to make you reevaluate your attitude. That’s actually pretty impressive. I wonder how you proceeded from that point. In other words, did you think anything further needed to happen to make peace with your emotions? For example, you might have considered apologizing for any abruptness or exasperation you might have conveyed; and you might have thanked her for succeeding where the doctors had failed! :-). Perhaps you did do something along these lines; or perhaps you judged that they were not necessary (you were the one on the scene after all). I’m also curious about what it was that helped the patient change his mind (once again!) and proceed with the endoscopy. Did he trust his wife more than his doctors? (sometimes, not such an unreasonable choice :-)). Did she understand the root of his fear better than his doctors? (again, not unlikely).

In any case, --, I appreciated your honest reflections about “the case of the patient who could not make up his mind.” Thank you. Dr. Shapiro

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Dear --, I am so sorry that you had to go through this frustrating situation all alone. I felt especially bad when I read your sentence, “I’m not sure what I could have done differently…” I’m not sure either! In fact, your persistence went above and beyond the

call of duty. You tried every avenue open to you, from talking a few times directly to the resident, to raising the issue with the team, the attending, the clerkship director, another resident, the social worker. I'm surprised you didn't talk to the dean (just kidding, especially since we don't exactly *have* a dean at the moment). At every turn the system failed you. This is not your fault, but obviously you end up feeling helpless and rather cynical about the whole situation.

I believe what you ran into is a systemic failure, and your essay identifies it insightfully. Medicine is a profession that is supposed to police itself; but unfortunately, what happens too often is that instead of prizing transparency, openness, and acknowledgment of imperfection, it priorities opacity, denial, and averting one's eyes. This may be deemed loyalty by some, but that is only because the system has only very limited ways for addressing problems. We are not used to talking to each other honestly but helpfully. We do not see constructive criticism as constructive, but only as critical. Thus, as you painfully discovered, small problems are ignored (the resident initially not adjusting the medication) until they grow so big no one can get around them (and sadly, this point has obviously not yet been reached with this resident). At that point, it is very unlikely that there is going to be a good resolution.

--, all I can say is that this should have played out very differently. I am particularly disappointed and shocked that the clerkship director "counseled" you, as though your behavior was inappropriate, as opposed to taking your concerns seriously and respecting your insights. But at every step along the way, the system let you down. Even though you did not get the results you deserved, I hope you will not waver in your conviction that turning away from mistakes and collusion with wrongdoing do not represent the best of medicine. You were one lonely voice that was eventually overwhelmed by a code of silence. But stepping forward was absolutely what should have happened; and I fervently hope you will have the strength to do so again, should the need arise (and hopefully with a much better outcome!). Best, Dr. Shapiro

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Hi --, thank you for your reflection about a difficult patient-family-team interaction. It is perceptive of you to pinpoint changing teams as a frequent source of difficulty. I would have been interested to understand more about how the new team treated the patient and his wife "differently." Something I have observed is that, if a patient has a lengthy hospital stay with the same team, everyone gets to know each other and is invested in the patient. The new team has no history with the patient (except the chart); and sometimes the patient's circumstances have deteriorated significantly, and the family member has become increasingly anxious, desperate, and frightened. But the new team never knew the patient and family as they were – only as they are now. And sometimes they are harder to connect with.

Case managers are there for a reason; but I think you are right that often problems and misunderstandings can be addressed and worked out between doctors, patients, and

family members if they are not ignored. I admire the fact that you were able to step up and plug the hole a bit. It sounds like you did some real good.

I very much like your practical proposal for these kinds of "touchy-feely" issues to be anticipated during changeovers. I suspect it would save a lot of grief! Best, Dr. Shapiro

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Hi --, your essay describes an encounter that is both interesting and very sad. It is hard to know exactly what happened as (I think) there are somewhat conflicting stories from family and from nurse about the patient's early level of consciousness. However, setting that aside, I very much like your analysis of the family suffering a "traumatic" event. These were the things I noticed in your essay: "The wife… approached us hysterically... At first the team ignored her…" "The wife angrily answered…" "The wife began to blame…" "…addressing our attending hysterically she pleaded…" "…to what to appear almost her breaking point" "…appeared helpless…" The expression on the face of the wife… was sheer panic and chaos." Taking a step back from the situation (hard to do *in* the situation!), it is pretty clear that the discussion should not be about CTs or no CTs or the mental status of the patient (or at least not only about these issues). You are describing a woman in the early stages of shock and grief. As you insightfully state at the end of your reflection, she needs support, guidance, and help in understanding what is happening to her husband.

But she (and her daughter) are not the only ones severely (and understandably) traumatized. Consider these sentences: "[The nurse] held her ground stating the wife was crazy" "We left the room feeling as though we were part of a natural disaster. As though we were the first responders to a terrorist bombing or 9/11." In a rippling effect, the entire team has succumbed to a kind of PTSD response. Intense emotions have a way of doing this – spreading, like contagion, from one person to another, and then manifesting in their own particular way. This is exactly the kind of situation where someone – hopefully the attending physician – pauses, takes a breath, looks at the big picture, and sorts out what the family member needs – not ignoring, not being told she's crazy, but someone to acknowledge that her husband may likely be dying. It's hard in the midst of the *sturm und drang* of the immediate circumstances to change perspective, but it would have been very helpful to this wife and her daughter (it sounds as though perhaps this did happen to some extent when the attending invited the family members into the conference room).

Thank you for sharing this difficult incident. Best, Dr. Shapiro