Art of Doctoring Group 1 Session 7 2/24/04

Dr. X was our guest as a positive physician role model. A asked a question about how to truly serve patients compassionately and empathically and resist oppressive systemic forces that encourage more callous, indifferent attitudes. B responded that medical students were actually her main source of inspiration for cultivating empathy. She went on to say that the challenge is not how to develop empathy during medical training, but rather how to maintain empathy in the face of factors which tend to extinguish it or treat it as irrelevant. In her opinion, most medical students begin their training with excellent innate empathy, but medical training often works in opposition to this quality.

When asked how she maintained her own empathy, Dr. X attributed it to her contact with students. She said patients sometimes elicit an empathic response in physicians, but also can trigger anger or frustration.

C asked about how to balance personal and professional lives. B responded that she sets firm boundaries in her personal life, especially around evening work. She also uses her long drive home to decompress.

D asked about working with difficult patients. In his one month experience at FHC, he had seen a steady stream of patients who didn't listen to their doctors, didn't comply with their medical regimen, and didn't seem to care about their health. He found these patients extremely frustrating and "a waste of time." E probed this attitude, attempting to facilitate a process of self-reflection. We learned that D experienced this attitude among patients as "disrespectful" to the physician. He also revealed some cultural influences on his thinking. For example, in his culture of origin, doctors are venerated, and seen as figures of respect and authority. Patients unquestioningly follow doctors' orders. C supported his view, noting that she came from a culture where it was very difficult to access health care, and people who finally received medical care were invariably appreciative and grateful. In this country, by contrast, patients seemed to take health care for granted, a right not a privilege. F noted that she did not experience the same frustration as D, but agreed that the physician could only present the information, then it was up to the patient to use it. All three students stated that when they reached a point where "there was nothing more they could do," it seemed pointless or a waste of time to "keep repeating" the same information to these recalcitrant patients.

B addressed this issue by saying that when she got to know difficult patients, and understanding their perspective, they usually became a lot less difficult. She also mentioned considering the difficulty many patients at FHC have in accessing resources, buying medication, or prioritizing their own health. She further disclosed that the patients she found difficult were wealthy, entitled, demanding patients.

E clarified that emotions of frustration, anger, helplessness are not wrong, and that the goal is not to "not have" these feelings. Rather, the point of reflection is to see if you can't understand the feelings at a deep level rather than simply reflexively acting on them. G noted the idea of questioning the stories we reflexively tell ourselves to

reinforce our initial emotions. By carefully exploring our emotions, we can discover the underlying assumptions that produce them. For example, if a noncompliant patient is perceived as disrespectful, that "justifies" and likely increases feelings of frustration and willingness to "dismiss" the patient. If, as D shared, he believes that when a physician "dedicates his life to patients", patients have an obligation to respond with appreciation and compliance, then there is an implicit contract in place that, if violated, again "justifies" feeling frustrated with the patient and "throwing in the towel."

E suggested the possibility that there might be other ways of understanding the doctor-patient relationship. A shared his view that treating disease sometimes can be less important than creating relationship, and that success in medicine needs to be measured in more ways than simply curing the physical problem. E reminded students that the majority of illnesses are now chronic ones, not susceptible to simple solution. H said that rather than reach a point of "quitting" on the patient, he tried to be creative about brainstorming different approaches to enlisting the patient's cooperation. I summed up with the insight that physicians often have "invisible strings attached to their patients" that influence the way they interact with them, and make it more likely that they will miss what's going on in the patient's world.

E pushed students to consider *why* a noncompliant patient produced feelings of frustration, and whether other emotional reactions were possible. [We did not pursue this direction, but it would be possible that such a patient could produce feelings of challenge, compassion, enjoyment, curiosity etc. depending on the meaning attached to the patient's behavior]. He similarly encouraged students to explore whether they agreed with D's assertion that in many situations, physicians knew what was best for the patient. The point that emerged from this discussion was that although the physician might be able to say fairly definitively that a certain drug would lower blood sugars, for example, the patient might have a very different view of the significance of this achievement than would the doctor. The statement assumes that physicians and patients prioritize certain outcomes equally, which is often erroneous.

E suggested the model of physician as consultant to the patient. He noted that physicians themselves often ignore the advice of their medical consultants, and are therefore "noncompliant" with the medical advice they have sought out. The consultant provides expertise, exerts influence, and shares her assessment based on her best understanding of the situation, but recognizes that the patient may reject the guidance, or even accept it, but be unable to act upon it. In this model, readiness to change is critical, which is something the consultant can facilitate or encourage but not compel. If the doctor-patient relationship remains intact, regardless of level of compliance, then when the patient is "ready" and motivated to engage, the physician is there and also ready.