AoD 2016-2017 CLINICAL OBSERVATION ASSIGN 3

I tend to agree with you. Parents who have done everything humanly possible to keep a severely disabled child alive tend to have found redeeming aspects in this choice, so it is probable they would not paint an entirely negative picture. On the other hand, the new parents can see for themselves at least one likely outcome, anchored in a very tangible (as opposed to theoretical) way.

--, the crux of this very sad situation lies in your last line: "truly informed decision." Parents may opt for highest level of care picturing to themselves a healthy, bouncing baby who grows into a vigorous child and accomplished young man. Really absorbing that this likely will not be the case is where "truly informed" comes in. No one knows for sure, of course, as you point out. But choice should be made from as honest an understanding of what (may) lie ahead. Kids do surprise and they are very resilient. But in a case like you describe, the outcome is almost certain. Perhaps the parents are ready for this; and perhaps they feel that even in these circumstances, their child would have some meaningful quality of life. These are the very hard decisions that people must make. But however they do so, physicians have an obligation to help parents understand and be prepared for a long-term future that acknowledges the likely severe severe limitations of their child.

And the patient's response shows that the attending's demeanor can really influence the encounter in a positive or negative direction. Unfiltered countertransference can escalate conflict, whereas respect, interest, and caring can down-regulate the intense emotions that make such challenging situations even more difficult.

No, you can't win 'em all. As of course you know, patients with chronic pain issues and perhaps addictions are notoriously hard to treat. But the attitude your attending displayed (as well as medically appropriate limit-setting) is the best chance for developing a therapeutic contract. Further, that physician will feel good that she treated her patient with compassion and respect - basically like a human being. You can't control the outcome, and if you are too attached to success it suggests a lot of ego is involved. Better to try your best and accept the end result rather than blaming the patient or yourself.

--, this was a valuable observation about how best to approach a patient dealing with chronic pain and perhaps addiction. As you know, there is no magic bullet. A physician can encompass pure compassion and caring (while setting medically appropriate boundaries) and the patient can leave AMA. Still, I'd argue that a respectful, calm approach has the best chance of reaching the patient, especially in an outpatient setting where you might have more than one chance. Treating people like human beings, rather than as types, is always a good first step. You can't guarantee success, either for yourself or your patient, and learning how to accept this will go a long way toward avoiding burn-out for the physician; and keeping an open door for the patient.

--, it was so nice to read your perspective on a physician I've known and admired for many years - and you showed me a side of him of which I was not aware! Your essay highlights the importance of preparation and planning for family conferences, which honestly often does not happen at the level necessary. You see clearly how thinking through goals, gathering the right people, assigning tasks, and above all ensuring that the patient is fully incorporated into the conference process will lead to a positive and beneficial outcome. The idea of a debrief following the family conference is something I haven't seen before, but seems especially valuable both for ensuring that everyone is on the same page and for extracting learning points. Thank you for paying such careful attention to the way in which Dr. X connects with his patients in a way that is both humanistic and respectful. I agree, many good lessons here.

Well said, --. The physician is not a neutral bystander in this process. In a gentle, compassionate, and clear way, the doctor's role is to help family members see perspectives that they may be missing, including the patient's wishes! It is still the family's decision, and families should never be brow-beaten into a decision the physician thinks is best; but they also need to understand the difficult reality of the situation from their loved one's point of view.

--, Dr. X is a great role model, and I'm glad you had the opportunity to participate in this family conference that he facilitated so skillfully. You identify very well the key elements that made it successful - understanding the family's concerns, getting everyone on the same page, being honest, and emphasizing the patient's perspective.

When family members believe that, based on previous statements of the patient, the patient him/herself would want a particular course of action, it does ease their burden, as you point out. This is always a very sad situation, but when it is handled well it does minimize unnecessary suffering for the family.

Annoyance is frequently how judgment is communicated - you are wasting my time; you are being unreasonable; you are asking pointless questions. Patients/ family members feel this judgment deeply, and it can poison the patient-doctor relationship.

--, you paint a moving scene that touches the heart: in the midst of the chaotic bustle of the ER, one physician takes time to be fully present with the patient's son, to ask him his understanding of his father's condition, and to give him permission (not a shove) to let go. And all of this is done without irritation, without judgment, but rather with genuine concern for both patient and family member. As you still recall, much of this was effectively communicated through a calm, comforting tone of voice, as well as the ability to really be in the moment with that son. I'm glad this memory has lingered, and that it guides you to this day.

Dear --, thank you for this reflection on your chosen specialty. I agree, anesthesiologists have unique constraints on the doctor-patient relationship - and yet, with the good ones, it is palpably present. I like the way your role models still managed to recognize what a privilege it is to answer patients' questions when they are poised on the brink of a precarious life moment. I also liked the way they tailored their approach to the qualities and characteristics of the patient, able to practice patient-centered medicine even in a very short time frame. Finally, I know checklists are very important in anesthesiology; but as you conclude, seeing the patient as something more than an item to be checked off is what will keep you enlivened and inspired.

Yes, very impressive. We sometimes forget that the "emotional atmosphere" in an exam room is established not only by the patient but also the doctor. The tendency is to mirror patient mood - so if patient is hostile, physician is guarded; if patient is happy, physician is relaxed and jovial. But the physician can choose to take an

emotional stance different than the patient; and because of the physician's authority, this can actually shift the feeling tone in the room.

Dear --, thank you for sharing this absolutely charming story. I agree, this cardiology fellow had really impressive interpersonal skills. Notably, he did not panic in the face of patient's agitation and distress, and also did not withdraw or punish. Instead, he seemed to embrace the situation as an enjoyable challenge, and set out to win over his recalcitrant patient. The rollercoaster analogy was beautiful, and the image of you all singing the Frozen theme song together was enchanting! The fellow showed both emotional tenderness and emotional steadiness, as well as creative improvisation and problem-solving. You chose a great role model and were alert to learn everything you could from this small but significant encounter. Your conclusion "understand who the patient is" sums it all up perfectly. When you know that, it will show you how to proceed.

These kinds of remarks are understandable in a high stress environment such as medicine, but that does not make them right. These are often signs of burn-out and compassion fatigue. They should be cues for some honest self-assessment on the part of the person making them, rather than excused as simple "letting off steam."

Courtesy goes a long way toward making a patient feel respected; and concern for a patient's comfort (which doctors sometimes feel is the nurse's "job") makes that patient feel cared about and valued.

Dr. X sounds like a great role model! --, you did an excellent job of identifying specific attitudes and behavior that make him such an outstanding physician. First, I like that, despite the demands of his work, he did not allow himself to complain or demean others. This is always unprofessional conduct and sets a very bad tone that can reverberate among colleagues and staff. Secondly, you noticed his consistent courtesy toward patients and his concern for their comfort, among other "small things" that reassure the patient and make him or her feel valued and cared for. Finally, you highlighted a style of communication that emphasized sharing of knowledge, bringing everyone onto the same page in a way that was respectful rather than patronizing. Your observations make me think both that Dr. X is an outstanding physician; and that you too are an outstanding physician for recognizing his interpersonal kindness and attentiveness.

It must have been a very intense experience. It is emotionally difficult but also a privilege to be so moved by another person's story.

While you cannot elicit such in-depth stories from every patient, in certain cases, hearing those stories are essential to patient healing. Figuring out when you must elicit those stories I suppose is the art of medicine. At the least, however, we need to remember that everyone is carrying those stories around inside them, and perhaps that will make doctors a little more tender and patient with their patients.

--, this encounter with patient and fellow was very nicely observed. I'm imagining that, as an old soldier, this patient might want a "regiment" or a "unit" of some sort to support him in this last phase of his life. The fellow seemed to step into this role with great skill, someone who was trustworthy, who had the patient's back, who would go the distance for him, and ultimately would support him in his EoL planning.

Your point about the family perspective is very well-taken. I don't know if the fellow talked with the sister, but these conversations are also critical, in that they can help remind family to put patient at the center; and that doing so is a true act of love.

--, this encounter was very well observed and analyzed. You drilled down with one specific statement to figure out why it had such a powerfully beneficial effect on patients. Your insights were very perceptive. I especially liked your awareness of how Dr. X overcame the "disadvantage" of being a male and managed to still connect so well with his patients. I also agree with your conclusion that, although you are aiming to be a "surgeon of the mind," the skills Dr. X demonstrated are easily generalizable to the psychiatrist's office: humility, confidence, identifying shared goals, respecting patient autonomy are always appropriate in any doctor-patient relationship.

You know, this is a step many physicians omit - reinforcing patients/parents for what they're doing right. Praise from the physician usually means a lot to the patient; and

also changes the common dynamic of shame and blame that can become entrenched between doctors and patients.
Dear --, thank you for the close attention you paid to this small, yet significant encounter. You found a plethora of lessons in a simple exchange. An important point was how Dr. X helped these new parents see the big picture (is baby healthy vs. do all his numbers conform exactly?). Also, she took their concerns seriously, acknowledged their efforts to be conscientious and good parents, tailored her explanations to their preferred form of evidence, and use appropriate touch to reassure and comfort. These are all skills that have a place in most patient encounters.

This was a very validating - and perceptive - comment from the fellow. I'm glad that at least you received some support for your concerns from someone within the institution. Indeed, in these circumstances, it seems to me you (and the other medical student) were the only ones speaking on behalf of the patient. I wonder - was it ever suggested to obtain an ethics consult? It seems to me that the ambiguity around capacity had become an ethical issue.

Dear --, Wow. I am humbled by your courage and persistence. It is very hard to lead "from the bottom" (of the medical hierarchy) but sometimes you have no choice. You became the voice of this patient, and importantly, worked tirelessly to truly understand what that voice was saying. You were dealing with overwhelming barriers (language and cultural differences; the requirements of a very specific religious belief; fluctuating cognitive capacity; complex family dynamics; and perhaps worst of all, the entrenched conviction of the culture of medicine that medical students have little if anything of value to impart to the team). Yet, in the face of all these obstacles, you just kept stepping up. In reading your story, it was almost like watching a boxer getting flattened again and again; then just rising up for more. I have great admiration for the tenacity you showed, the determination to help this patient when everyone else seemed content to superficially evaluate him with the goal of coming to a convenient but facile conclusion so as to move a discharge forward.

What happened with Mr. X shows that Mr. X shows that it is not only about the outcome in medicine but the process by which that outcome is reached. In the end, you and the team agreed that Mr. X indeed had capacity to make a determination

about his treatment. The difference was between evaluators who seemed more interested in checking a box than in understanding the patient; and a hail Mr. X shows that it is not only about the outcome in medicine but the process by which that outcome is reached. In the end, you and the team agreed that Mr. X indeed had capacity to make a determination about his treatment. The difference was between evaluators who seemed more interested in checking a box than in understanding the patient; and a hail Mr. X shows that it is not only about the outcome in medicine but the process by which that outcome is reached. In the end, you and the team agreed that Mr. X indeed had capacity to make a determination about his treatment. The difference was between evaluators who seemed more interested in checking a box than in understanding the patient; and a hail Mary interaction that strove to respect his integrity as a person (and to get the rest of the team to do so as well).

--, I'm sorry you had to work so hard to protect this patient. But in the end, this is exactly what you did, and is what shows me you will be an amazing and fearless physician on behalf of your future patients.

Of course, as you know, there are so many difficult encounters in medicine. Outstanding physicians learn not to be afraid of these interactions, but to see them as a privilege - the opportunity to share and support patients in a really critical moment in their lives.

--, you always see deeply into doctor-patient encounters, and this is no exception. Your observations regarding this attending showed careful attention to even small, but significant, behaviors, language, and actions that established a trusting relationship. I think your overarching point is that an excellent physician knows something about the patient as a person, as well as about their disease.

I think it takes courage on the part of the physician to encounter the patient as a person in these very sad and painful situations. But if the physician is willing to take the risk, the rewards are many - and not only for the patient, but for the physician as well. This kind of I-Thou encounter (in the words of the philosopher Martin Buber) allow both doctor and patient to express their common humanity. This benefits them both both, even under such difficult circumstances

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Excellent point about the bread-and-butter --, regardless of specialty. I have often observed the attitude - this is so basic, how can you not get it, in explaining "common" problems to patients. It's easy to forget that for the patient, it's the first time; and that their comprehension is complicated by emotions of fear and distress. Your attending's patience and thoroughness are commendable. The idea of tailoring explanations to the needs and questions of the patient is what makes an explanation patient-centered, rather than rote. I'm glad you had such a great teacher - and glad for the patient as well!

You know, I was taught by one of my role models that pain is always "real," included the dreaded "whole body" pain. It is just that the patient's explanation (physical) and the physician's (emotional, spiritual) may differ. This patient is "in pain," it's just that modern medicine may not be able to do much for her.

Dear --, you learned an important lesson from Dr. X about calling out a malingering patient; and perhaps an important lesson about empathy as well. You know, I think it is possible to see with clear-sightedness and also with compassion. Clearly, this woman is suffering and is in dreadful life circumstances. We can be empathetic to her plight. Can western medicine help her? Probably not much if she refuses anticoagulation therapy. Is it wrong to recognize that, in a desperate bid for some kind of help or shelter, the patient is malingering? Absolutely not. So it is possible to both recognize her pain and to admit that a hospital setting can offer her little in the way of assistance. Like a patient seeking narcotics, she is simply doing the best she can to ease her pain. We don't need to collude with her attempts, but we can understand them. I think a patient like this is hard to see, and easy to reject, because she makes us aware of all our shortcomings as a society. There are pitifully few resources to help someone like her begin to piece a life back together.

Dear --, I'm glad you've had such a superb role-model. Even better, you were not only globally in awe of Dr. X's skills, but were able to carefully analyze the reasons why he is such an outstanding physician. By distilling out specific practices and attitudes for emulation, you increase the likelihood that you will be able to incorporate something of Dr. X's talents into your own practice. I was particularly struck that you also mentioned your "daily life." it is very true that one's professional

life and one's personal life are not completely separate things - who you are in one informs who you are in the other. Moderation, empathy, and respectful responsiveness make for good people as well as good doctors.

Excellent point, --. Empathy without trust and dependability is a cheap trick ("I feel your pain" when in fact, as Dr. X points out, the physician cannot imagine the patient's experience). In fact, I'd argue that true empathy grows out of trust in the sense that the patient has learned to open up to the physician; and to share her situation more authentically, thus enabling the physician to empathize even as she sets limits.

Awesome. In general, I think physicians do not celebrate their patients' "small victories," which sometimes can be almost undetectable. Too often, the patient leaves with a sense of falling short, a sense of failure and inadequacy. A physician who counteracts this message - who has hope in her patients even when they may have lost hope in themselves - is a beautiful thing to see.

Dear --, thank you for an example of humane, respectful treatment of sickle cell patients who often, as your attending points out, dismissed as drug seekers. It is a dreadful disease that enmeshes patients in a world of opioids and untangling a path forward that is best for the patient is complicated.

I agree with your insightful observation that empathy is not the only important component in the doctor-patient relationship. In fact, I don't think you can have deep empathy until there is a certain level of trust between patient and doctor; and until, in some sense, you both feel you can depend on each other to be honest and open. When these conditions are met, even when there are differences as to how to proceed, the physician will be able to feel true empathy for the patient's situation. This genuine feeling in turn will increase trust and affirm reliability.

Finally, I very much like your recognition that physicians not only need to point out to patients where they need to improve, but how much they've succeeded just by getting themselves to the doctor's; or staying in school; or helping their family. Your term "small victories" is very well taken; and sometimes no one else in their lives is recognizing these. Believing in the potential of your patient (not naively, but hopefully) is a great gift.

Very nicely done, --. Students often choose to write about Dr. X, he is indeed a great role model. You've penetrated to the heart of the matter - establishing a human connection with the patient is good both for the patient and the doctor. Forming a bond with your patients will foster their trust and it will make you a happier, more fulfilled practitioner.

--, it is a joy to encounter such an outstanding role model. You are also to be commended for paying attention to WHY she was so effective as a physician. Your point about educating through analogies is an excellent insight, as is your realization that the truly exemplary physician treats everyone - not just patients - with respect and caring.

Yes, there is a lot of mirroring that goes on - when the patient is motivated and eager, it is easy for the medical team to be engaged and go the extra mile. Conversely, when the patient "doesn't care," the team feels hopeless and ends up "caring less." Caring for the patient is frustrating and unrewarding, resulting in avoidance and superficial interactions. It's a vicious circle.

Again, a really astute comment. Because he is despairing and pushing the team away, they are pushing him away. The patient's situation needs to be confronted directly and compassionately WITH THE PATIENT so that he can begin to come to terms with what is and participate in the difficult choices that lie ahead.

--, I was really impressed by your sensitivity to the team dynamics in response to this patient's progressive withdrawal and hopelessness. I think this is a not uncommon phenomenon in medicine, yet one that is insufficiently discussed. The patient's situation is dire, with no obvious good solutions. Nevertheless, from an ethical standpoint, it seems this reality needs to be discussed with the patient; and he needs to receive the emotional and psychological support necessary for him to come to terms with his current condition. I agree that a better approach for this patient would be continued efforts to include, engage, and respect him.

Actually, this is a really complex topic in medicine. (See The Racist Patient in JAMA and different options for responding). Whereas you might speak up more readily with a person in a social situation, the therapeutic contract complicates what comes next. I believe there are ways of separating oneself from such blatantly racist/homophobic comments without losing patient trust, but setting an appropriate limit on such speech.

As long as the patient understands the doctor is saying, there is no place for this LANGUAGE, not there is not place for YOU, I think this is an important limit to set. Just as we don't allow smoking on premises because it is bad for patients' and others' health, racist, xenophobic statements are also unhealthful and can reasonably be restricted in the hospital environment.

This is a very important topic, and you are asking exactly the right questions. When nothing is said, the risk is collusion with the statement; the patient concludes you agree and endorse their opinion, or at least tolerate it. It is important to be ready to render care to all kinds of people, but this does not imply that certain kinds of racist, bigoted language need to be accepted. I feel this is particularly true when such comments are directed toward a member of the medical team. When a patient says, "I don't want that Muslim to treat me," (which I have heard happening), often the team stands around in uncomfortable silence - and the target of such an attack feels isolated and alone. Even if this person is too shocked to know how to defend herself, others can say, "So and so is the best trained doctor we have to take care of you" or some comment supportive of your colleague and boundary-setting on the patient. It is important never to view the patient as the enemy; it is also important not to miss opportunities for thoughtful and respectful challenge.

--, you did a superb job first in choosing an outstanding role model; and secondly, in analyzing so carefully how and why Dr. X is so successful in earning the trust and confidence of his patients. Your sense that he "celebrates" his patients is insightful; and it is worthwhile to consider how to do that with your own patients. You also noted his interpersonal abilities of listening carefully, paying close and interested attention to his patient, and creating an atmosphere of inclusion and participation for

all concerned. By anchoring your general admiration in such specifics, you have a much better chance of incorporating these qualities into your own patient care.

--, this is such a memorable encounter: from tears of fear and resistance to tears of relief and gratitude. Importantly, with patience and kindness, the attending was able not only to put the patient at ease, but even have her consent to a pelvic - a remarkable accomplishment. It is understandably hard to break free of the "business as usual" mold; and sometimes there is a personal cost (here, the physician's schedule is messed up for the rest of the day). But as you saw, it can make a huge difference for the patient - and I'd argue ultimately for the doctor, who now had the satisfaction of being able to care for her patient in the way that could best help her.

--, thank you both for noting the important step that was taken by the palliative care team; and for recognizing the effect it had on the family, and indeed on everyone in the conference. As you say, omitting this leads to confusion and disagreements. Starting with where the family - or the patient - is essential to moving forward with cohesiveness. I'm glad that this has become an ingrained part of your own clinical interactions..

--, you are so lucky to have spent time with an old-style family physician like Dr. X. Their model of care is dying out (more's the pity) but there are many lessons that can be learned from these practitioners. You list most of them, including, importantly, the ability to know each patient as a person; and to treat each patient as a member of one's own family (I'm still chuckling over the intense encounter with Dr. X's patient-father). I appreciated your vivid description of the exam/negotiating table. I imagined the many conversations that occurred in this setting, some enjoyable, some more difficult, but all occurring within a context of trust and caring. I suspect after this experience that, despite the many challenges, you will figure out ways to carry Dr. X's bedside manner into the future.

Very well said. And I'm sure the team was correct - this patient was "inconvenient" for them because she didn't conform to the image of the ideal patient - optimistic, grateful, cooperative. Sure, things go more smoothly with patients like this - but this is not at all where the patient was, and no wonder. Healthcare providers have to always be patient-centered, which means starting with the patient, rather than starting with themselves. I don't mean this judgmentally, because this can be very hard to do; but it is central to what being a healer (physician, nurse etc.) means.

Another outstanding observation, said in a way that for me casts new light: "they don't even notice it." When you have rejected a patient's full humanity (which is what happens when they are dumped into the bin of "difficult patient," it becomes easier to ignore their suffering.

--, you are always very insightful in your comments, and this essay is no exception. Your awareness of how the medical team can "push the patient away" sounds very recognizable to me. I was really struck by your observation that, once the patient is labeled as "difficult," her suffering is not even noticed. This is how patients become objects, and it seems natural not to care about them. As you say, we all encounter people we put into that "difficult" box - I think this is just human nature. But your awareness that in so doing patient care suffers is a key step in challenging our own judgments and biases. You saw this patient clearly, warts and all, and this is what every patient deserves.

Hi --, thank you for this well-observed essay. You do an excellent job of bringing these two "characters" to vivid life. You go on to show how each reacts in either a surprising or predictable way to a poignant moment in patient care. I love that the fellow used his high status and "cool guy" reputation to promote the art of medicine.

This is a good example of more "horizontal" mutual help in contrast to physician-patient help, which can feel more "vertical." In the group dynamic, people facing the same struggles reach out to help each other; and sometimes this sort of help can be very effective.

A very hopeful observation. If we treat others with respect, practice active listening, and show sincere empathy for their situation, even when we do not share a similar background, connection is possible.

--, I'm delighted you had this experience, and I agree it can be a tremendous learning. As I noted, I went through a similar training many years ago, and I still remember it vividly. I learned a great deal about myself; and I also learned the power of being vulnerable and authentic in building trust with others. I think you learned both how important it can be for people in similar situations to help each other; and how even when you do not share a common background, it is possible to connect with others if you approach them with humbly and with respect.

--, your essay was so thought-provoking because it challenged certain well-grooved ways of thinking I have about what constitutes "good" healthcare. I'm not sure that we should adopt a model of 60 patients every two hours, but what was so valuable about your essay was your identification of the deeper assumptions that made this grueling pace work. It sounds like patients and doctors both recognize that the needs are greater than the ability to meet them; and therefore both doctors and patients are required to make superhuman efforts. They agree. There is something generous and self-sacrificing in this attitude which I agree is by and large missing from western medicine. Then, as you point out, there is a sense of comeraderie, an awareness that both doctors and patients are linked by shared suffering and common humanity. I think we lose sight of this in the west as well. This was a really eye-opening essay. Thank you so much for sharing your perceptions.

--, beautiful dissection of the oft-used term, "patient-centered medicine." Here you've identified crucial elements that put this valuable concept into practice - desire to interact with patients and families; active listening etc. You are so right that "difficult patients" often become "easy patients" when someone listens with respect and a desire to understand there needs.

Dear --, I was so relieved to see that you've discovered some superb physician role models. There are so many physicians I've admired over the years, who have taught me so much about medicine. None of them was perfect, but they were all people I was so glad to find doing what they were doing.

Your observations about the palliative care team are keenly observed. Everyone, especially administrators, throws around the term "patient-centered care" yet it is much rarer to see it put into practice. Active listening, as you note, is a big part of it; and honesty is another. Finding out what the patient wants and needs; and being frank about the realities of the situation build trust and confidence. It takes courage to be this kind of doctor, and I think it will suit you very well :_).

As you probably know, many studies document declining PE skills in medical students. Ideally, the balance between imaging technology, labwork, and old-fashioned observation, palpation, and auscultation results in a more accurate diagnosis. Overreliance on any one modality may be to the detriment of thorough assessment.

I would agree, so long as "being nice" doesn't disallow having honest discussions about difficult topics. I have noticed that physicians who have longstanding friendships with patients sometimes find it difficult to broach sensitive issues because of this aspect of their relationship("We need to talk about your drinking"). Yet bonds of caring, trust, kindness, and respect will smooth the way for such conversations. The human dimension is always the foundation of the clinical encounter. The physician must be ever mindful that it is used to advance the patient's wellbeing.

Dear --, this is an excellent observation of what made this family physician such a fine doctor. NO EMR! - I can just hear the envy of so many physicians! :-) Also, he clearly takes the PE seriously and trusts how much he can learn by careful listening and close inspection. Overall, what comes across most strongly is his personal knowledge of his patients. I doubt it will be possible to avoid the EMR in your future, but you can hone your physical exam skills, and you can certainly develop meaningful relationships with patients. As you note, this will not only please your patients but will gratify your need for social interaction. A happy doctor makes for happy patients!

And there it is. No bells, no whistles, no frills... just the barebones question - is this life worth living for you? Are you ready to let go? Whatever else about this attending, I admire that he could confront the biggest issue that is so hard to address;

yet without an answer to this question, it makes a mockery of all other medical interventions.

--, this was an extremely impressive essay. I especially appreciated your "field notes," and seeing how you crafted them into a thoughtful, perceptive, and brutally honest essay. All your conclusions are really terrific - that medicine needs to place its capacity to keep patients alive within the context of what you call the "big questions" (is this life meaningful to the patient?' does it still have moments of pleasure?; does the patient want to continue this life?); that decision-making capacity can be assessed more broadly than reliance on the 4 questions; that it takes courage to ask patients about their preferences for end of life; and that family and friends, bearing the responsibility of DPOA, may confuse their own desires and needs with those of the patient. You've really thought this through beautifully. I know you will be ready the next time patients and families need your courage and your honesty.

--, you've done an excellent job here of identifying Dr. X's many strength - from a calm demeanor to confidence, reassurance, and compassion. Each of these is an essential component of skillful doctoring, as you observed.

Dear --, I was impressed by your careful observation of Dr. X, and how much you absorbed from these rounds. It is always a worthwhile exercise, I believe, to pay attention to the professionals around you (and not just your superiors, but medical students, nurses, social workers etc.) because they all have something to teach us. In particular, I think that combination of confidence and compassion is very meaningful to patients. Confidence alone can slip into arrogance, while compassion without a context of competence (from which confidence derives) can lead to more distress in the patient. I'm glad you found such an excellent role model who could teach you both

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Brilliant. This is the key. Many students say, Dr. X is so cool. But when I ask HOW Dr. X manages to be such a great doctor, they are at a loss. The secret is close attention, so that you can identify specific ways of being, and then make them your own (not just imitate!).

This last is not a specific behavior, but it is perhaps the most important of all. Some of Dr. X's most important skills as a physician arise from her ability to genuinely care about her patients. Patients sense this and it builds enormous trust and confidence. I wonder what she would say if you asked her how she does this. I suspect she'd just smile.

Dear --, I'm impressed by the way you took time to not only admire Dr. X but to analyze (very perceptively I might add) exactly why she is such a remarkable physician. Your observations identify behaviors and practices that you can easily incorporate into your own practice - with the exception of caring, perhaps the most important. Caring for one's patients is, I think, not a behavior but a way of being; and it is from this deeply held moral stance that all the other positive behaviors and practices flow. I have no doubt that this caring is already part of your DNA.

In my own life, there have been many instances when I have held back and remained silent. I think sometimes that has been the right choice (i.e., I misread the initial situation and judged too quickly) and sometimes it has not. In the latter case, I have paid the price of being disappointed in myself. The targets of the comment have paid a price in seeing that no one would defend them. And the perpetrator paid a price by being unchallenged in his or her wrongheadedness or bias. I see these as very complicated situations, but try to urge myself in the direction of thoughtful moral courage.

--, I appreciated your recognition of how ethically wrong these snide comments and validating (although embarrassed) laughter were. I also appreciated your authentic wrestling with what is the right thing to do. I think each situation is different. It is really important to figure out what you think is the right thing to do; and then you have to decide the costs (to you, and possibly to others) and benefits (to others, and possibly to you). This is not a simple calculus. It takes a great deal of moral courage to step forward; and sometimes the benefits actually do not justify the risks (attending may learn nothing; you might get a bad eval). But sometimes they do (MS3s would see a positive role model; your standing forth might encourage others on the team to do the same; the attending might actually reevaluate her words). When possible, standing against what you know to be wrong is a course of integrity and growth. But none of us can do this all the time. Then we must forgive ourselves, and be ready for the next opportunity. This must always be the individual's choice,

based on a thoughtful weighing of pros and cons.

--, you may be familiar with the literature that exists on this topic of having family members observe CPR efforts. It is controversial, but those in favor make exactly this point - families see everything that is being done for their loved one, and they viscerally experience the effort made. Opponents argue that families need to be protected from the brutal reality of the procedure, but I think you make a good point - families are already immersed in suffering at this point, and a "protective stance" may be both irrelevant and patronizing. Just as we want the patient to be part of the medical team, so we should look for ways that families can appropriately be brought in as well (a well-run family conference comes to mind).

--, this anecdote raises a very interesting issue of the extent to which families should be included in the patient's care. I'm not sure there's a one size fits all. The real question to ask is always, how will this benefit patient and family? In this case, your attending made an informed decision to perform CPR in front of the patient's wife so that she could see the team was fighting hard to save her husband. This might not always be the right call, but considering the pros and cons seems a much better way to proceed rather than rigid adherence to an institutional policy. I think whatever helps the family feel that they are on the same side as the physicians, that everyone wants the same thing (i.e., best possible quality of life for the patient) should be what drives such choices.

--, thank you for paying such careful attention to this interaction, you noticed many important nonverbal ways in which your attending conveyed his concern for the patient and his wife. In such a situation, it is easy to imagine the physician becoming exasperated with the patient. Yet this did not happen; instead, the doctor managed to remain the ally of his patient and wife, always interested in understanding and addressing their concerns. Your awareness of your own body language will be invaluable in your clinical practice, as it is something harder to monitor than verbal behavior, but actually much more important.

I think you would agree that there is a difference between honesty and judgment - actually a very big difference. One addresses the elephant in the room; the other accuses the patient of being the elephant.

Well said, --. A good advocate does not simply do whatever the patient wants. Rather the advocate authentically shares his/her perspective on the wellbeing of the patient and the best path to reach this goal. I firmly believe that when such conversations occur within a context of respect and caring, both patient and physician benefit.

Thanks, --, for tackling this difficult topic and for seeking to educate yourself and clarify your views as much as possible. I feel you make a strong case in this essay for honest, direct communication with patients about the challenges of effective pain management that will not interfere with patient wellbeing. Doctors must not be afraid of having these conversations, even if patients become angry and upset. The best safeguard (although by no means an infallible one) against this outcome is to not approach the patient with judgment but with caring and compassion - even while holding the boundary you think to be in the patient's best interest.

Thank you for this careful observation, --. As you noted, it was indeed a "sad and chaotic scene." In that moment, the physician's behavior could either help or harm. Fortunately, what occurred reassured the patient and absolved her of guilt. Physicians are often present at critical times in patients' lives, and have the opportunity to ease their suffering or to compound it. You had your eyes wide open to realize how important the physician's intervention was at this juncture. Thank goodness the situation
was handled so well.

Dear --, what a remarkable experience in that it clarified so well what you are looking for in a specialty and where you are most likely to find it.
I hope you are proud of the way you conducted yourself during that procedure. In a polite and unobtrusive way, you resisted the mechanistic culture of the team to offer a little human comfort and support to a patient who must have been feeling vulnerable and scared. This is not at all easy to do, and I commend you for the simple acts of taking the patient's hand and helping him understand what was happening.

I'd also suggest this is how cultures change - when someone stands up and challenges them.
I'm glad you've decided on a specialty that will give you plenty of opportunity to build relationships with patients and care for their wellbeing on many levels. Ob-Gyn is lucky to have you, and it is IR's loss (imho).

Dear --, I really liked the connection you made between humility and listening. I'd never thought of this in exactly the way you expressed it, but it was very illuminating in terms of why humble physicians (or people) are good listeners. Your insights about individual stories, getting to the root of the patient's concern, and knowing how to make the patient feel that they had time to explore their concerns all lie at the core of good doctoring.

Very well observed, --. I like that you realize that lines of communication which have broken down can be rebuilt with the right attitude of listening, eliciting concerns, and engaging the family. Although it is best if possible to head off such breakdowns by using good communication skills from the get-go, these situations are more often reparable than not, if the physician team leader is willing to alter their approach and work with rather than in opposition to the family.

Thank you for this carefully observed encounter, --. It is easy for the physician/surgeon in such a situation to be frustrated and irritated, to see the family as "standing in the way" of good patient care. Yet the family is simply trying to save their mother pain and suffering. Dr. X was able to listen, express empathy, show concern, and show the family that they shared common ground of wanting to help the patient. As you noted, even when the situation has become strained, a respectful, listening approach can often repair the rifts that have developed. Dr. X is a master, you had the opportunity to learn from the best, and you made the most of it.

--, you chose a superb role model; and also did a wonderful job of thinking carefully about WHY Dr. X is so successful. Your observations about his love of teaching are well-taken. Your sensitivity to the small things he does - sitting down, taking a patient's hand, listening to their story - is impressive.

I was intrigued by Dr. X's "zipping," which I'd never really identified. It's fascinating to me that this is a conscious choice he's made to send a message of proactive availability. I thought your comment about the relationship of this habit to burn-out was so perceptive. Maybe this is how Dr. X maintains his "joy."

Altogether a perceptive and uplifting essay.

Of course it is better never to drive the nail in, than to pull it out. But as you say, physicians are only human and of course will stumble on occasion - and this is true interpersonally as well as medically. Fortunately, with sincere repentance, most interaction errors can be remedied. A heartfelt apology and a willingness to start over can work wonders, as your attending demonstrated.

--, I really appreciated this essay, which took a little different tack than many I've read. Notably, instead of presenting an amazing physician interaction, it showed a physician stumbling out of the gate. Wait, was she confused about the assignment, I thought. But you got it - beautifully. The good doctor is NOT the perfect doctor because news flash there are no perfect doctors. Rather, the good doctor is the one who is self-aware, who realizes when she or he makes a mistake, who is nondefensive about the mistake, and acts as quickly as possible to remedy it. As you say, most patients will appreciate this human-to-human encounter. It shows them their doctor is not afraid to admit wrong, and is ready to take corrective measures. I enjoyed reading these thoughts, they make a much needed point in our conversations about "the art" of medicine.
