AoD 2017-2018 ASSIGNMENT 1

What you realize here is that, by ignoring the problem with the mom when it was small, it created a much larger and more dangerous problem later. It is always wise to pay attention to the small things and give family members or patients an opportunity to voice their concerns when they can be addressed more easily.

Great example, --. In this essay, you realize that differences in the perspectives of medical team and mom could have resulted in the baby leaving the hospital AMA with possible negative consequences due to incomplete antibiotic administration. As you note, it is so important to always keep the two (or sometimes more!) perspectives in mind - what you know to be true as a physician; and how the situation appears to the family or patient. Especially in pediatrics, parents of sick kids can get a little crazy, and they will do anything to protect their child (as they see it). Not acknowledging this dynamic can lead to a lot of unnecessary and dangerous conflict. You drew exactly the right conclusion, and I'm glad you were able to persuade the mom to allow her baby to complete treatment.

Whether or not the father was "reasonable," (I think you got a glimpse into some less than optimal dynamics in this family), you are quite right that illness does not tend to bring out the best in most of us. It is frightening, stressful, bewildering, and leaves people and their families feeling helpless and out of control. When you add "special circumstances," people act in ways that in retrospect they find embarrassing. It sounds like this is what happened here, and you had the grace to hang in with the dad so that his son would get the best healthcare possible.

This sounds like a very frustrating situation, and I was impressed with how you handled yourself. You not only kept calm in the face of verbal abuse, you proactively pursued the father, set limits, and provided him with a clearer, more logical way of thinking about an unexpected and alarming situation. I think you did tap into some less-than-optimal family dynamics; but these are not uncommon, and stressful circumstances tend to exacerbate existing patterns. I agree with your conclusion that it is always wise to give people the benefit of the doubt, while not being swayed by their inappropriate behavior. I thought you did an excellent job of helping the father reframe the current situation to bring him more in line with the medical and

regulatory guidelines; as well as respectfully got him to reflect on strategies he used with his son that imparted unskillful lessons about honesty and the importance of healthcare. You handled this difficult encounter very well; and I hope all ended well for the kid as well. beiswayed by their inappropriate

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Very well put, --. And I think it goes beyond "feeling" like an essential part of the team to actually BEING an essential part of the team. You probably realized on other rotations how much value students can contribute to the medical team. Any attending who does not know how to maximize the student's role is falling short of optimizing care of the patient. The medical student is not a useless appendage, and should never feel such.

Dear --, you identify an extremely important issue in this essay: the critical role that good team functioning plays in contemporary healthcare. Fortunately, your experience as an ignored medical student will likely not be repeated, but trouble on teams is a not uncommon occurrence. Even when a team works well, there may be conflicts between teams. Acquiring some basic knowledge of group dynamics and how to resolve difficult situations can help.

I have great appreciation for your determination to always be your best self regardless of circumstances. You showed your value to the team and I hope they saw it. I think this kind of modeling can change hearts and minds. Sometimes it can also be important to speak up about injustice or mistreatment, and directly surface the problem. This is not always effective either, and can pose some risks, but it can also be a necessary step in challenging an entrenched culture.

Dear --, this essay is very perceptive regarding the relationship between pediatricians and parents. Pediatricians love kids (most of them!), but they sometimes see parents as obstacles, especially when they are demanding or, as in this case, neglectful. The truly great pediatricians do as you did - reach out to these apparent impediments to their child's health and try to understand what is going on. This is not the same as excusing inappropriate or inadequate behavior, but it enables you to see whether there can be common ground going forward. Are there ways of supporting the parent to become more involved with her child's care? Is it possible to help her prioritize

her child's health? Sometimes the answer is no; but often, simply by hearing and respecting the parent's struggle, you can work together to brainstorm improved parenting. As you say, it is almost impossible to help the child without also helping the parents.

Dear --, the way you handled this difficult situation showed humbleness, nondefensiveness, and prioritizing the team above your own needs. I'm really impressed. In conflict, it is always important to own what you have contributed, even if it is small. This makes the other person feel safe and may trigger their own nondefensive self-examination. Nevertheless, there is really no excuse for the way this social worker behaved. To be a productive team member, he might require counseling (not from you, but from his supervisor) about how to conduct himself in a professional setting. Yelling and cursing are never acceptable methods of conveying displeasure or concern.

Dear --, it is a truism that in clinical encounters, people are not always at their best. The patients are often scared, angry, and experiencing loss of control, a terrible interruption of their life story. Doctors can be stressed, overworked, time-pressured, burned-out. It can be a tough combination! Recognizing this, however, can help the physician modify her initial responses and compensate for the patient's less than ideal behavior.

I agree that sometimes simply avoiding a conflict-prone situation is a good solution, if neither the patient nor you will suffer as a consequence. However, as you note, you'll always encounter patients who question your expertise, regardless of your level of training or clinical experience. So learning how to be comfortable in and address these situations is a crucial skill.

Finally, not every patient who challenges your authority is mentally ill. They may be simply grumpy, frustrated, frightened, etc. A mental health referral or psych eval is appropriate under some circumstances, of course. In other situations, just being able to sit with the patient and find out what's bothering them, what they are worried about can help resolve tensions.health referral or psych eval

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Yes, good point, this is exactly what I was wondering. You mentioned the patient had been consented on admission for "all procedures," but how much did she really understand about what might happen? It is clearly not ideal in an emergent situation to try to explain all this, especially across language and culture, so revisiting the possibilities, while painful, might have helped.

Dear --, this event sounds very distressing for everyone involved. You and your resident made sound choices in an emergent situation, and tried to maximize the patient's understanding of what was happening. I was touched by your decision to stay by her side, and to pull along the video translator, trying to reassure, explain, and comfort. You were a good doctor to her.

In terms of managing emotions, I suspect there will be many times as a resident and even as a physician when you will feel fear. There is nothing wrong with that, in fact fear probably keeps you humble. Your resident might have felt a little afraid too. What's important is managing the emotion - acknowledging it, even thanking it for the alertness it brings, yet not being afraid of the feeling, or being overwhelmed by it. It is like holding two opposing things at once - yes, I'm afraid; and yes, I am competent to handle this situation and help this patient. In other words, you don't need to be afraid of fear!

--, thanks for completing this essay. Often our most difficult encounters are our most rewarding ones because of the work it takes to move them forward. And sometimes the patient is an immovable object and cannot be moved. More often, however, if you resist getting hooked by the patient's acting out, your persistence and patience win them over. Most patients are in the hospital because, beneath their anger and suspicion, they want to be helped. You saw this clearly, and that is precisely what you offered your patient. Indeed, as you describe, it was the quintessential human connection, one human being in need asking another for help and another human being, despite past history, ready to extend a hand. Often that's all it takes.

--, this was an instructive essay for me as well, since I'd never heard of this constraint, although I'm aware that many cultures associate menstruation with impurity. In this case, it is not surprising that there is a cultural/religious workaround, since making

the Haj pilgrimage is a requirement of all devout Muslims, and half of these are women who can't always plan around their period. As you say, the lesson learned has to do with always eliciting the "reason why" a patient is adamant about something. Even when the answer falls outside of medicine, expressing concern and support as you did will make the patient feel less alone; and encouraging the patient to contact community or religious leaders if appropriate may help to resolve the issue, as in this case. I'm glad it turned out well for her.

So in an interesting way, you have (very appropriately in my view) taken on responsibility not only for the patient in front of you but also for the innocent lives he might harm in the future. This is the crux of your ethical dilemma. question becomes, what course of action is likely to do most good for your patient while safeguarding to the extent possible innocent lives?

I agree with your attending. Pretending to an ideal of perfection only means suppressing human feelings that will still affect the interaction, all the more so because they have not been acknowledged and brought to the surface. Once you recognize your anger and judgment, you can begin to choose what you will do with them.

If I'm understanding you correctly, I think you're saying that you had one idea of who you would always be no matter what the situation; and this encounter forced you to nuance and complicate this view. In my mind, this was an important and valuable development, because it moved you closer to your human, imperfect self. This honest self awareness paradoxically gives you the opportunity to make more conscious decisions about how you will act, feel, and think about such patients in the future.

--, thank you for sharing so honestly and authentically about your reactions to this patient. I think many students and health professionals in your situation would have had similar feelings but, as your attending observed, would not be willing to admit them. What you were able to do through this encounter was deepen your understanding of the complexities of the human condition.

In that regard, I'd say that there is a difference between blaming/shaming and discernment. To me, the former says, "You are a despicable person with no

redeeming qualities. I don't care what you've suffered or experienced, you are a monster." Discernment says, "Your impulses (or behaviors) are unequivocally wrong and do irreparable damage to vulnerable others. You've had many difficult experiences in your life that have helped shape you, including your struggles with mental illness. Nevertheless, we must work together to figure a way forward so that you do not harm others."

In other words, you can have compassion for a severely troubled individual while being very clear that nothing excuses his acting on his desires. Your job is to do your best to get him the help he needs, and in doing so you will protect his potential future victims in the best way possible.

--, I'm glad this painful encounter ended so well, and I commend your perseverance in simply trying to be as prepared and knowledgeable for your patient, regardless of the circumstances. I think there are several good lessons as you note: 1) Things that seem obvious often become less so if we take a minute or two to listen 2) Speaking on behalf of individuals who are less powerful (whether medical students or patients) is an important ethical an important ethical decision 3) No matter what the pressures of time, work, personal issues etc., it is never the right call to yell at team members (or others), using tactics of shame and blame 4) When you make a mistake, the right thing to do is always to apologize. Thanks for sharing this incident.

This is a wise conclusion, following the "readiness" aspect of motivational interviewing. I do think there is a difference between "educating" a family member and educating a patient, in that you can be more persistent with a patient in "leaving the door open" for the "healthy conversation; and probing patient ambivalence for the part of them that wants to change. This is part of the expected role of the physician, whereas it is not part of the role definition of a niece!

Dear --, your experience with your uncle shows why it is so hard to be "doctor" to your family members. There are usually too many role conflicts to do this effectively. I also agree with your extending the lesson you learned to patient care - with some caveats. "Telling" patients how to live (the usual form patient education takes) is rarely effective unless the patient is at a high point of readiness for change. However,

techniques such as motivational interviewing can help the patient feel in control and understood; and can elicit and strengthen the reasons they themselves might wish to alter their behavior. You are absolutely right that, in general, the patient should lead and the doctor should follow. As the physician, however, you have the authority to respectfully explore with them whether they want to start the process!

Two things are troubling to me. One is that, even if the patient did indeed lack capacity, should he have been overtly lied to by his physicians? Is there not another way to deal with this situation? The second, as you point out, is the lack of convincing documentation to establish this crucial point. If in fact the patient was not incapacitated, then his rights were violated. As you point out, it is quite possible that stereotypes about this individual contributed to the decisions by both psych and ethics.

--, this is certainly a troubling situation, even to read about. I can see why you felt conflicted. I hope I am not missing the point of your essay, but I think it rides on the determination of capacity, which of course is not necessarily negated by the presence of mental illness, even schizophrenia. From your description, it is not at all clear that he did in fact have capacity to meaningfully consent; but the image of the patient screaming and begging "no surgery" as you sedate him is very distressing. It sounds as though important steps in determining capacity were followed, such as a psych evaluation and an ethics consult, but the lack of adequate documentation is worrisome, since this will guide decision-makers and actors who were not physically present at these events. With more time, more patience, more efforts to win the patient's trust, could his fears have been elicited and allayed? Could he have been consented? Or could he have continued to refuse surgery with his caregivers' confidence that in fact this was an informed decision?

Your concluding point is both a fine one and an upsetting one. If the patient did not have a history of schizophrenia and drug use, might a greater effort have been made to thoroughly evaluate capacity? As you realize, this may indeed have happened, but this patient may also have fallen victim to prejudices and assumptions on the part of the very people he relied on to help him.

I am not sure that a moral error was committed; but I am not sure that it was not. I appreciate that, having no authority and only peripheral involvement, you nevertheless wrestled with the question.

--, these are all insightful and empathic hypotheses. You are really trying to see things from the patient's perspective. Quickly you see SO MANY things might be underlying his resistance, uncooperativeness, and anger. The next step is to sit down and try to ascertain which of these possibilities might be contributing to his behavior. To be honest, if complex psychological and environmental factors underlie his hostility and defiance, it may be hard to turn these around in the inpatient setting. Nevertheless, your best tool in winning trust and cooperation is listening and trying to understand his point of view.

Excellent! Thank you for appreciating that there are (at least) two people involved here and that BOTH of them bring issues to the encounter. The surgeon, as you surmise, will likely be feeling responsible. If the patient does not follow his postoperative instructions, then ultimately he is culpable: bad surgeon, no communication skills. This makes it likely that the surgeon will pressure the patient to comply; and when this doesn't work, label the patient as difficult and uncooperative, so the blame will fall on the patient rather than the surgeon. This is all very natural and understandable. However, a better approach is to sit down and, as you suggest above, explore the many factors that might be the root of the patient's resistance. The surgeon can't fix any of these issues, but sometimes just listening and communicating (through paraphrasing and nonverbal behavior) that you understand and empathize can lead to the patient adopting a more receptive attitude. Or not. These are complex situations.

Could I suggest nuancing your thinking a bit here? Perhaps it is not that the patient "doesn't want" to care for himself so much as that (to borrow a concept from Dr. X's presentation) he is ambivalent. Partly he wants to get better and partly it seems too overwhelming and hopeless. Partly he wants to take better care of himself and partly he wants to enjoy one of his last remaining pleasures - food. Partly he wants to live and partly he may feel he doesn't deserve to. He did come to the hospital and he did consent to surgery. So the question becomes, is there any way to strengthen the part of him that wants to keep going? Maybe yes and maybe no, but this is the issue that should be explored.

Dear --, this is a thoughtful and perceptive essay. Your awareness of what might be going on with both patient and surgeon shows great awareness of the interpersonal dynamics that can influence the process of communication around a "content" issue such as proper postoperative care, and lead to a negative outcome, as it did in this case. As you suggest, the most important thing is to find out from the patient what is the underlying issue for the anger/resistance /
defiance or noncompliance. Never be afraid to ask your patient: "Help me understand. What's going on? What are you thinking? You agreed to this surgery, but now you do not want to follow the steps to help you recover. Help me understand this." When you approach patients' seemingly illogical or annoying behavior with genuine curiosity and interest, you can learn a lot.

You also did an excellent job of analyzing the surgeon's
dynamics. If the surgeon feels s/he will be judged based on the patient's outcome, s/he may pressure the patient inappropriately or blame the patient to deflect negative consequences to him/herself. Awareness of this dynamic can mitigate unskillful behavior and lead to more creative thinking about the patient. Finally, sometimes you just have to say, I've done all I can and I still haven't been able to build trust with the patient or find common ground. This is very sad, but it is occasionally part of medicine. So long as you can look in the mirror and say I did my best, you should not feel that you - or the patient - failed.

Here I agree with you completely. There are many, many difficult conversations in medicine (between doctors and patients, doctors and family members, nurses and doctors, colleagues and doctors) and all too often they are avoided and ignored to the great detriment of all involved. However, in my view there is an important difference between directness, honesty, and brutality. Sometimes people say (and may believe) that they are doing something in another's interest when they are really indulging themselves. From your description, I think the attending could have made exactly the same points with equal clarity but much more kindness.

Dear --, thank you for sharing this difficult encounter with an attending. The lesson you came away with is such an important one - learn how to hold difficult conversations, because there are so many in medicine. Aspects of such conversations include clarity (vs. obfuscation), directness (vs indirectness), and honesty (vs.

deception). However, such conversations also require compassion and kindness as a context for the difficult things being said. The content of your attending's advice seemed excellent to me - but leaving in the middle of your presentations, embarrassing you about your bag, joking about your being a chauffeur were all unnecessary and inappropriate. Always think about how you deliver the message as well as the message itself. Still, I'm glad to hear that despite the mistakes this attending made, you were able to separate the wheat from the chaff and use her counsel for the benefit of your patients.

It is true that patients are autonomous beings, and when competent, should have the freedom to make their own decisions. For me, the question is always, is this an informed choice, made with full understanding of its implications? All too often, people take actions that are not really actions so much as REACTIONS to their feelings of anger, helplessness, and powerlessness. In these cases, it is not so much that the patient is making a carefully reasoned choice as they are lashing out against their disease, their perception no one cares, and their loss of control. Leaving AMA is often the only way patients feel they have left to regain some sense of control.

--, I think the thing to think about here is in what sense you cared "more" about the patient's health than he did. You clearly cared a great deal by spending 7 hours solving a horribly frustrating and frightening situation for the patient - only to apparently be rebuffed. What do you think the patient competent patient from doing what he wants. But sometimes - perhaps not in this particular situation - there may be a way to help the patient over the wall. Circling back to my original statement, is the patient making an informed choice; or is he crying out for help? There is only so much you can do for an individual patient, and even when they are screaming for help, they may not accept the help you can offer was feeling? After all, this was his 7th visit to the ER in s month. What was he feeling about the quality of his care? What might he have felt about how much his doctors cared about him? What might have happened to his attitude and motivation during the 7 hours he waited in the ER? His behavior suggests at least a part of him did care about his health. At least a part of him doesn't want to die, since he keeps coming to the ER. But maybe something "broke" (hopefully temporarily) in the patient. Maybe he just hit a wall. Of course, you cannot prevent a mentally competent patient from leaving AMA (as happened in this case). But it's always worthwhile to think about what is really motivating the patient's behavior and what they moti what they need from you.

Dear --, great conclusion - "there is always more to the story than meets the eye." Using this maxim as a guiding principle leads you to probe deeper, learn more, rather than judge and make assumptions about the patient. You are so right that sometimes providing good clinical care to the patient requires patience and openmindedness. The way you worked with this patient shows you have both in good supply!

--, this sounds like an awful situation, so unexpected and unanticipated by everyone. In my view, you handled it perfectly. Your physical presence (sitting close, holding the mother's hand) conveyed more powerfully than words that you were there for her. I don't know that the mom was searching for another explanation so much as she was searching for a different reality - which sadly you could not give her. When patients and family members ask for information, you should give it. But information can only stabilize the situation so much. It may reduce confusion and clarify misunderstandings. But it will not resolve grief. Only grieving and time will do that. You handled a very tragic situation extremely well.

These are all good ideas. I'm not immediately struck by any huge clinical significance to the detail about high school, and as you point out it could have calmed the patient's paranoia. You could have followed up the deletion with a probe: "Help me understand what was worrying you about my writing that down." In terms of the third point, I suspect that with experience you will become more confident in distinguishing when you need to be scared and when you don't. You may have panicked unnecessarily in this circumstance, but better safe than sorry. Often in these situations, our instincts are more important than our prefrontal cortex!

Exactly. This excellent insight acknowledges that you can't fully control the outcome of your interactions. You can work with your own attitudes and actions, but you can't guarantee the patient's response. The patient is often dealing with history and issues far outside your influence. A good physician does the best she can, tries everything she can think of to improve the situation, and then accepts the lack of success when necessary. In family medicine, there is usually the opportunity to try

again, if the physician does not become too self-condemnatory or resentful of the patient.

--, what a perceptive and self-aware essay. You did an impressive job of self-evaluation and self-assessment. I think you were a little hard on yourself, but I also think you identified some real areas for growth in yourself. It is a great skill to be able to look at yourself not with shame and blame but with interest and compassion, and be able to say, I'm doing good, and in these ways I could do better. When you stop evolving and learning is when you stop being an excellent physician.

Your insights about panicking too quickly, being too reactive to the patient's emotional state, and struggling to calmly and gently set a clear boundary all sounded true to me. My only cautionary note is that sometimes you are in danger from a patient, and knowing when to step away, involve a third party, or call security are also important skills.

Finally, your awareness of your humanness and therefore your lack of ability to transform every difficult situation into a happy outcome is humbling - and true. You can't save everyone- but everyone deserves your best efforts. These tend to manifest when you manifest when you are calm, centered, and attentive.

From your description, this sounds like the path of least resistance, rather than the medically correct decision. I can understand why a busy physician would opt for this course, but as you pointed out to the patient there could be negative consequences such as reduction of "good" bacteria and antibiotic resistance. You presented a good argument, but it did not convince the patient. What else might you try? (paraphrasing her concern [sounds like you think you really need antibiotics; you don't seem to be getting better], eliciting her fears [you're afraid you won't recover without antibiotics], seeking compromise [if symptoms persist for X days, call my office and I will email you a prescription]). I think the idea is to be able to try several different approaches before simply "giving in" to the patient's demands.

I think you've got it exactly right. When the patient trusts you are working together, even if there is a difference of opinion, in most cases they will eventually accept your judgment; or you will find a successful compromise; or, when the risk to the patient is very slight, and the expense inconsiderable, you may take an unnecessary medical

step to show you are willing to accommodate the patient. There is no universally right answer for all circumstances. In general, however, I think physicians do not know how to set boundaries kindly, so avoid them altogether.

--, you highlight an important issue which comes up all the time in clinical practice, so it is a good idea to pay attention to it and learn how to handle it skillfully. The key, as you say at the end, is never to allow the patient to feel you are "against" them. No matter what, you are on the same side. The best way to do that in a fraught situation is to keep paraphrasing, reflecting, and empathizing. When the patient feels heard, seen, and respected, they will be more likely to trust your differing viewpoint.

--, your anecdote reveals just how uncertain cross-cultural communication is, especially in fraught situations where you are literally discussing life and death. Even with a common language, who wants to understand this?! In addition to promoting bilingualism in schools, we also have to improve the interpreter system. This is largely a matter of will and money. Often, patients needing interpretive support are not wealthy, well-insured, or high-status. Rather, they can easily be dismissed, many of them so unfamiliar with the healthcare system they cannot effectively advocate for themselves. Their "voice" becomes a disembodied overworked underpaid interpreter. There are certainly steps that can be taken in the individual encounter (such as teachback and paraphrasing) to try to ensure comprehension and address the emotional distress of the family. However, ultimately we need institutional and societal solutions so that people not fluent in English will not receive second-class healthcare.

--, I was impressed with your insights and risk-taking in this situation. The mom was the identified patient for the team - everyone disliked her and for good reason. But this reaction, which undoubtedly the mom felt, only made her more entrenched of what she probably perceived as advocacy for her child (rather than, as the team saw it, annoying, unrealistic, and demanding behavior). Finding out something of the mom's story - and especially the shared diagnosis - was an important first step in humanizing mom. Your excellent comment, not blaming or judging, but recognizing the mom's suffering, was really skillful; and she felt your caring, and responded to it. No, it didn't turn the tide. Mom was still mom. Still, it served to turn a tide in YOU.

By seeing the pain and distress beneath the anger, you had more understanding for mom and hopefully this insight suggested additional ways of interacting with her. Allowing ourselves to see the suffering of others always moves us closer to them. Thank you for an honest and perceptive essay

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--, this is a sad case of a patient who was relegated to superficial care, guaranteed to repeat the futile cycle of discharge and readmission. He was "saved" by the determination of one courageous medical student to advocate on his behalf. Patients like Mr. X are often victims not only of their disease but of structural inequalities and violence that have predisposed them to suffering multiple injustices. Add to that, a physician who sees the patient primarily as a problem, someone who "does not care about his health" and should be discharged as quickly as possible, a view which itself emanates as a consequence of structural violence (some people are more deserving of care than others).

For your patient's sake, I'm glad you had the tenacity and conviction to champion his cause and fight for the healthcare he deserved. I think of the many patients who have no one to speak for them and cannot speak on their own behalf. That is why it is important to fight for change on a societal as well as an individual level.

This is the kind of outpatient encounter that happens all the time, and can easily resolve or go completely south depending on how the physician handles it. You demonstrate some excellent skills in terms of apologizing, paraphrasing, understanding the patient's perspective, drawing on your own experience as a patient, and showing a benefit to the patient of the numerous repetitions. You and the rest of the team of course have not done anything wrong - as you point out, this is how a teaching hospital hospital operates. But seeing it from the patient's point of view stimulates empathy and transparency, as it did for you. You managed the situation very well, and as a result were able to somewhat shift the patient's attitude in the direction of more cooperation and less anger. Good work!

I can understand how frustrating, even heartbreaking, this must have been - one step forward, and two steps backward. I wonder if you were present when the attendings

appeared to actually conduct the procedures; could you have served as any sort of "bridge" back to his previous trust? It might not have made any difference, but it sounds like you were the one person who could pierce the veil of his paranoia, albeit temporarily.

Hi --, thanks for sharing this example. In this case, I think your options were limited because of the patient's disease-related cognitive changes; and you definitely seemed to maximize every opportunity to build rapport and gain trust. I'm assuming that despite the dementia and paranoia, the patient was deemed competent to make decisions about his own healthcare. In that case, all you can do is what you did. It might have made some difference if you had been physically present when the attendings came to do these procedures - but perhaps you were, and it didn't help. In meeting with him, you might have reminded him that, even though he agreed to undergo the procedures with you, he backed away when the actual time came; how understandable that was, given his suspicions and fears; and to strategize how he could remember that you'd reassured him and given him your word that these were in his best interest. Again, these ideas might not have helped. The main thing is not to be dissuaded by "failure," but to keep thinking about creative ways of reaching the patient. Not every action succeeds in medicine, as you well know. It sounds like you did enough so that the process of persuasion had a chance of continuing on an outpatient basis. Kudos to you for the effort you bestowed on this person. It was clear you formed a real connection with him; it was simply not strong enough to override his disease.

I can only imagine how frustrating it must have been for you to walk into the room, only to be bombarded by the wife telling you how to treat the patient and giving you interesting but medically irrelevant information about his past. Still, is it possible she's giving you valuable information that will help you take care of her husband (because for better or worse that will involve dealing with her)? Could she be telling you something about how she is her husband's protector and guardian? Could she be asking you to see how special he is, to see him as an amazing and valuable person?

Dear --, this essay has many important insights. First, you formed a meaningful relationship with a patient who had significant cognitive impairment due to dementia. This shows that relationships consist of many factors, only one of which is mental capacity and communicative ability. Second, you learned that reframing a

"difficult" patient or family member as acting out of love and responsibility rather than to make your life miserable can advance understanding and empathy. Finally, you realized that having a compassionate understanding for someone else's perspective is not incompatible with setting limits on demanding or inappropriate behavior. When you can say, I truly care about you, and we need to talk about your phone calls, that person will be much more likely to listen and even accept your boundary. It's all about feeling that you or your loved one actually matter to the doctor. That's a lot of learning you extracted from Mr. X and his wife - well done!

Dear --, I hear in your writing how this patient tested you to your limit, which makes your decision to persevere with him especially admirable. I agree both with your conclusion that such patients are often dismissed because this label makes life easier for their physicians; and that trust between patient and physician is essential for good care.

When patients behave in resistant, obstructive, and uncooperative ways, there is always a reason - fear, anger, helplessness. Often these reasons can be addressed and ameliorated (not ameliorated (not always). But the best chance you have of caring for the patient is to find out their worries and fears.

--, I am very admiring of how you handled this uncomfortable and highly inappropriate situation. It is really disgraceful that a fellow would "refuse to talk with" a medical student, or would browbeat patients and families into a course of treatment. It is often not easy to speak out against wrongdoing, especially when done by a superior and in a situation where your own self-interest may be in conflict with the interests of patients, families, and future training. You conducted yourself extremely bravely and professionally. It is only by surfacing such behavior and recognizing its inappropriateness that we can change a culture of silence and acquiescence that unfortunately still pervades much of medicine. With you, I hope that the fellow will reflect on his treatment of you and others, and realize he is not living up to his own standards as, in your words "a healer." such

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You can see right here what is going on - the patient feels her "eyesight is at stake" (even though you've told her that it is not); and she is receiving a test that is unfamiliar to her and that keeps yielding different (although all normal) readings. Given that she very recently learned her diagnosis, it is obvious that she is in a panic. You and the ED attending or resident might well have tried this, but in such a situation it is really important for the patient to feel heard by EXPLICITLY PARAPHRASING their fears. That takes more time, but look how much time was taken up arguing with her. Once you've let her know that you are taking her concerns very seriously, she may be more receptive to your explanations of why you trust your conclusions and why she should to. Or maybe not. She does sound very panicked.

Dear --, this essay shows A LOT of insight. Nice work! I agree with every one of your conclusions - dream with the patient, make sure tone and body language are aligned with verbal behavior, manage your (understandable) frustrated emotions. It really helps to paraphrase patients, so that they feel seen and heard. As your attending modeled, sometimes you can approximate giving the patient what she wants, and in doing so defuse the situation. Think outside the box: "We can't get an ophthalmologist down here; but what we can do is call, explain your case carefully, and get her recommendation." Always consider not only what you can't do for the patient, but what you can do.

The background you elicited about the patient (brother going blind, irreversible optic nerve damage, recent diagnosis of glaucoma) all help explain (although not excuse) her skeptical, aggressive, and demanding behavior. Many times, if you can make the patient feel safe, they will calm down and be more receptive to your recommendations. Fortunately, in the end, this is what happened with this patient.

I appreciated your final insights and and the way you extracted excellent lessons for the future from this encounter.

Dear --, I was heartened to read that you not only spent time with this patient but were able to elicit his wishes and convey them to the team. The result was that the patient was able to share his fears and to hear his physician's worries as well. It is hard not knowing, but it is harder to bear the burden of uncertainty alone. You handled this extremely well. Sharing possible diagnoses with patients is not always

the right move, but when the index of suspicion is high; and the patient clearly is already worried, I think it is better to carry the uncertainty together.

Yes, I think I understand this. As a medical student, there is literally nothing medical you can do or offer that will help this patient. I expect even her physicians felt something of this helplessness. Helplessness is unfortunately an emotion physicians need to come to terms with. Otherwise, it tends to push doctors away from patients who make them feel helpless; and then the patient is left on his or her own, without anyone to walk with them or witness their suffering.

Absolutely. Medical students - and physicians - often underestimate what a great gift it can be to simply be present with another, especially when that other is suffering and afraid and alone. It takes courage to confront your helplessness and then to set it aside to simply walk beside your patient.

Dear --, this was truly an extraordinary essay. I am humbled by what you've written. I think one of hardest things to do as a human being is to be present with another in the face of your own helplessness. This seems especially difficult when the whole purpose of your profession is to help and heal. Yet there are many times in medicine where at some point this becomes impossible. At that point, many physicians are so uncomfortable, feel so inadequate that they turn away from the patient, in effect abandoning that individual because they feel "there is nothing more they can do." Because every other doctor feels the same way, the patient ends up alone and desperate. By being willing to simply "stay with" the patient - by sitting beside them in the hospital, by continuing to see them as an outpatient - you confirm your commitment and your and your caring.

The most moving part of your story for me was when you chose to stay by the husband's side and help clean the patient's fistula. I saw this as an act of courage and of love (in the sense of the love all human beings should have for each other). I am sure you will go on to learn how to "better deal" with these situations;but if you only remember that simple gesture, in my mind you are already there.

It sounds as though you handled a challenging circumstance very well. I wonder if you ever felt you were lying to the mother (either by omission or commission). In

this sense, the patient's request put you in a difficult ethical situation, in which you might have had to compromise some of your own values; and deceiving the mother as to the patient's true diagnosis might have negative emotional consequences for her down the road. Nevertheless, in my view, you made the right choice, as honoring patient preferences must be your priority unless they are harmful to patient or others.

Dear --, this was a really challenging quandary. I endorse the conclusion you reached - you prioritized your patient's wishes for secrecy, thereby protecting his privacy. The dilemma arises in that, in doing so, you may be compromising your own values by lying to another (the mom); and creating possible future suffering in this person (should she discover her son's diagnosis, she may feel deceived, betrayed). While as you point there is no right answer, your professional guidelines as a physician require you to honor the patient's wishes unless they will lead to harm for himself or another; or unless your own personal values are so severely compromised that you could not continue care (anti-abortion doctor asked to terminate a pregnancy). In these complex situations, respect for all involved (including those holding antithetical viewpoints) and trying to do the right thing are indeed good guides for how to proceed.

Dear --, this is an excellent example of the importance of digging deeper. When a patient is nonadherent or resistant, it is very easy to fall into argument mode: Let me tell you why you are wrong and I am right. Unfortunately, this is often not persuasive if your arguments are not addressing the patient's underlying concern. Doctors often conclude they don't have time to listen to patients; but if they don't, they can reach an impasse which wastes time and resources. Understanding the patient's fears about anesthesia and the way she related it to what happened at her workplace, as you (and unfortunately only you) did, is an essential first step in letting the patient know you hear her concerns and can address them sympathetically while correcting her misguided ideas. I wonder if you were able to share the essential back-story you elicited from the patient with the rest of the team. This information may have held the key to helping the patient agree to the surgery she needed.

Dear --, the situation you describe was extremely complicated. The patient had 3 major problems: 1) Denial of his hypertension and nonadherence to medication 2)

Denial of ongoing alcohol addiction/dependency 3) Cluster B personality traits. Add to that a wife who colluded with him, specialists at see with all these issues, and transfer to another hospital, it is easy to see why little could be resolved. Even if the patient had remained longer at DH, it is difficult to be optimistic about the outcome.

Nevertheless, it is usually a good idea to start where the patient is - i.e., his demand that you "find the cause" of his hypertension. Perhaps with empathy (which might address his narcissistic, histrionic, and borderline tendencies), and teachback techniques, you could move him closer to accepting his diagnosis. Perhaps not. But given the seizure and his extremely elevated BP, there's a lot at stake. It would be great to refer him to rehab for alcohol abuse and counseling for his mental health issues, but as we know, Cluster B personalities do not tend to think there is anything wrong with them.

--, thank you for this insightful essay. I admire your thoughtful analysis of the perspective of the very people who were yelling and giving you a hard time. This is not easy to do, but shows true leadership. Rather than mirroring the nurses' (understandable) hostility which would have been easy to do (after all, you were only doing your job!), you took responsibility for overviewing the situation, considering the stresses on the nurses, and then creatively coming up with an approach that reduced burden and increased efficiency. The result, I'm imagining, was a happier, more smoothly functioning team. Empathy for others can lead to effective problem-solving; while defensively entrenching in one's own position exacerbates conflict. Really well done.

--, you made a great point that students get little training in these sorts of "difficult conversations" yet will be expected to conduct them regularly as residents. I'm glad you had the opportunity of a good physician role model, but I agree the process should be more systematized. Many of the principles we've been talking about in AoD are relevant: 1) Always take the time to listen, so you can understand the pt's/family member's concern thoroughly and with respect 2) Paraphrase and reflect, so the person knows you hear them 3) Thank them for sharing their concerns with you 4) Honor their advocacy for their loved one 5) Share your own thinking transparently, presenting both pros and cons honestly 6) Explain what you feel is the

best course, and ask for their assessment of it: Does that make sense to you? 7) Keep listening until doubts are resolved. I don't mean to suggest there is a formula for such conversations, only that we have some tools to help make people feel seen and heard, even in very difficult circumstances.

This additional information provides insight into the dynamics you observed; and unfortunately is pretty demoralizing. It is one thing to think of an attending spending extra time and providing extra attention to a patient and family who are frightened, upset, and confused about their care. However, if this extra attention is the result of the patient's power and wealth, this significantly changes my view. All patients deserve attention, care, and explanation. Wealthy, powerful patients do not deserve to be coddled because they don't like the care they're receiving; and in fact overriding sound medical judgment in such cases may actually be detrimental to optimal care.

--, I appreciate your redoing this assignment. The purpose of the assignment is to give you a chance to reflect on difficult encounters; and as we both know, there are certainly more than a few of these in medicine!
Thank you for sharing this case, it sounds unbelievably frustrating. I didn't understand till the end that this was a high-status patient whom the hospital wanted to accommodate. I too have seen instances where patients receive special treatment just because they might make a fat donation to UCI Health. Such favoritism is unconscionable.

However, it is possible that this very aggravating patient was aggravating for similar reasons to other "difficult" patients - he is vulnerable, out of control at his body's betrayal, and terrified that he might be dying. I'm not asking you to feel sorry for him, and I certainly don't think he should be treated with privilege, but he does deserve the care we would extend to any patient; and this includes understanding (while not accommodating) his anger and his fear.

Nice work on this essay!

Dear --, it is a truism that in clinical encounters, people are not always at their best. The patients are often scared, angry, and experiencing loss of control, a terrible

interruption of their life story. Doctors can be stressed, overworked, time-pressured, burned-out. It can be a tough combination! Recognizing this, however, can help the physician modify her initial responses and compensate for the patient's less than ideal behavior.

I agree that sometimes simply avoiding a conflict-prone situation is a good solution, if neither the patient nor you will suffer as a consequence. However, as you note, you'll always encounter patients who question your expertise, regardless of your level of training or clinical experience. So learning how to be comfortable in and address these situations is a crucial skill.

Finally, not every patient who challenges your authority is mentally ill. They may be simply grumpy, frustrated, frightened, etc. A mental health referral or psych eval is appropriate under some circumstances, of course. In other situations, just being able to sit with the patient and find out what's bothering them, what they are worried about can help resolve tensions.