AoD 2017-2018 CLIN OBS

--, it sounds to me as though you chose a great role model. I've seen many physicians use the "If you were my daughter/mom/son" language, and in my experience, like yours, it is always reassuring because it conveys a sense of caring and commitment (as you would toward your own loved one). I've never heard of the earpiece, but after thinking about it, I can actually see it as being less disruptive for necessary interruptions while improving communication with staff. So kudos to this doc for introducing a new beneficial use of technology!

Yes, we want to make this man a monster, and in some ways he is. In another way, he was a loving father. We must learn to hold both truths simultaneously, while recognizing that the latter does not excuse the former. That being said, I really like the use of the word "tragic" to describe the father. This is a tragic situation all around, which does not diminish the father's culpability. A man has killed his child. We will never fully understand all the forces impinging on him nor the personal choices that have led to this devastating outcome. Tragic is the right word.

Thanks, --, for this thoughtful and heart-wrenching essay. You made a good choice in writing about this attending - in her remarkable compassion toward the father, toward patient and family, and toward future lives that might be saved through organ donation. This is a model of a physician who does not judge, but simply tries to do the best she can by everyone whom she has the opportunity to serve.

This is an interesting phenomenon, and I've seen it often enough (if you include residents and colleagues) that I think it does describe an actual pattern rather than just a one-off event. I can't really explain it, and it is very strange. The compassion to the patient seems sincere, and so does the animosity to the student or colleague. It is as if selective empathy is being practiced. Perhaps these physicians feel that some - vulnerable patients - are deserving of kindness while others - medical students who they feel get in their way - do not.

--, as you'll see from my comments, I also have observed and wondered about this phenomenon of selective empathy - it is as if patients deserve it, but students and

residents do not. You have a good insight about teaching as a mediating factor. Sometimes such physicians do not seem very interested in teaching either. It may also have to do with kicking the dog - to be rude to a patient may result in negative patient satisfaction scores; whereas students and residents are less likely to complain about unkind treatment. One day I'd love to ask one of these physicians, "Why are you so nice to your patients and so mean to your students?" I wonder if they'd even be aware of the difference!

--, I've always wondered about physician behavior in the trauma bay, so I'm especially appreciative that you reflected on the physician's/team's responsibilities to comfort as well as to address the medical needs of the patient. I have been hesitant to weigh in because of my lack of experience with this environment, so I am particularly glad to hear your opinion. The example you provide of team members reassuring and explaining to the little kid suggest, at least under some circumstances, it is possible to do both. I also valued the empathy you showed for the patient, who in these emergent circumstances is always going to feel frightened and desperate. Having someone take just a moment to reach out on a human level seems so important, so it's great to hear you don't think this is unreasonable.

Thank you -- for elucidating so clearly the specific elements that made Dr. X's communication with the patient's family about this complex case both effective and compassionate. Your point about hand gestures showed how carefully you were observing the interaction - it's something I'd never really considered. Your awareness of reflective listening is an important foundation of good communication. Clear, accessible explanations can heighten family members' understanding and reduce fear. I especially appreciated your awareness of the gap that often exists between what doctors chart ("family reassured," patient counseled") and what actually transpires. I know you will always remember that what happens with the patient and family is much more important than what happens in the chart.

Dear --, I recognized instantly the many shortcomings of hospitalist medicine that you described - the turfing, the dumping, the inappropriate discharges, the inappropriate stays, the orders falling through the cracks, the rapid pace and

impossible juggling - all true. I also recognize the frustration of your attending, which is completely understandable.

However, to stay immersed in frustration, no matter how justified, helps no one (including the doctor). I was deeply moved to read your concluding lines. You and your classmates are indeed bright lights. The challenge is how to continue to shine in a very imperfect world (medicine to be sure, but the larger world as well I'm afraid). When we are unable to move beyond frustration and resentment, we start to burn-out. Then I think the dark side wins, and we've lost another physician to cynicism and bitterness.

Figuring out how to "keep our lights shining" is no easy matter, and few people can succeed all the time. But remembering that that is the goal helps, as does knowing you have a chance every day, indeed every moment, to be a little better person. Of course you know all this, and I am weighing in simply to say - don't swerve, you are on the right track!

I agree. These are valuable questions, plus they raise the provocative possibility that not every physician can learn to conduct these conversations in a skillful and empathic manner. Ideally, the physician him/herself should be able to do so personally. I would want the person operating on my eyes to be at least one of the people who'd discussed the various possible outcomes with me. But I do think your idea of a team approach is an intriguing one. You would not want the patient bullied or intimidated however inadvertently by a large crowd of people explaining the procedure. On the other hand, having a few different perspectives and skill sets present could help the patient better understand various aspects of what was being proposed. Sometimes two or three heads really are better!

Having had several eye issues over the years, I can attest that eyes are fraught with significance, and even a simple cataract surgery can be unsettling (see attached poem). When I had a retinal detachment, the surgeon told me this would be a life changing event. At the time I pooh-poohed this comment as melodramatic, but he was right, much in my life changed as a result of that event. Remember "the eyes are the window to the soul." You always have a chance to encounter your patient's soul when you peer into their eyes.

I encourage you to borrow Dr. X's analogy, and to create analogies and metaphors of your own. They are a powerful and effective way of helping patients understand medical realities. I also agree with you that it is not only his analogies but his general demeanor - an impressive combination of equanimity and caring - that makes him so beloved and trusted by his patients. As one of my mentors used to say, "A good doctor has the steadiness to remain calm in the face of the patient's suffering; and the tenderness to care about that suffering.

I also was intrigued by your questions as to who is best equipped to conduct such conversations. While ideally every physicians should be able to handle such encounters with grace and clarity, knowing one's limits is also important. In the latter case, it might be helpful to bring in reinforcements. Further, even if the physician is sufficiently skilled to conduct the interview independently, involving a couple of other members of the team, including the medical student, might lead to a richer, more nuanced discussion. Good thinking!

Transparency in the physician is a wonderful quality. Sharing one's thought process rather than just the ultimate conclusion makes it much easier for the patient/family to understand how you reached that conclusion; and also engenders trust and a sense of inclusion.

--, you did a truly excellent job of identifying qualities in Dr. X that make her an outstanding geneticist. I was especially struck by her conscious use of language to acknowledge the value of each child. This is such a gift to both child and parents, and can be given so easily. I also appreciated the examples of compassion-in-action. Dr. X's ability to apply her knowledge about insurance and resources to each patient's situation was a concrete way of helping them navigate an overwhelmingly confusing and frightening situation in the best way possible.

--, thanks for getting in this final essay. I think you chose wisely in terms of a physician role model. I very much liked that she included the entire team - they were all involved with the patient's care and they deserved to be part of this crucial family conversation. I also liked that she didn't play God, but honestly acknowledged what she knew and what was uncertain. This attending succeeded in creating a sense of teamwork and cooperation not only with the medical team but

with the family as well. She was both confident and humble, compassionate and honest, which to me is the right combination when it is important to prepare family for the worst while leaving open the door to a small possibility of hope.

Very interesting reflection, --. I could see your respect for Dr. X and it sounds as if it was very well-placed. What struck me was the extent of your understanding of this patient. You comprehended in a very deep way the subtleties of her relationship to her original facial features; and why it was so important not only to repair damage, but to restore as familiar a look as possible. Your empathy was palpable - you might lack the technical expertise of Dr. X, but I think you would match him in grasping the essence of this patient's hopes and needs.

Nicely thought through, --. Additionally, it's helpful to see that a generic "be healthier" kind of counsel could be dropped into almost any conversation with any patient. It doesn't sound as though the doctor has invested ANYTHING in this particular patient. When the physician starts talking details, she sounds interested in the patient, in their life, and in how change might occur in that particular life. When the doctor seems interested, the patient might become interested as well. And then doctor and patient become a team, mapping out how that 5K will be worked up to. I happen to know Dr. X, and she is great, I'm glad you chose her as a role model, and glad you could appreciate the caring embodied in her down-to-earth approach with her patients.

Dr. X is a great physician role-model, and it's easy to see you benefitted from this experience with him. In the end, depending on the nature of your specialty and practice, you may not be able to (or even feel it is appropriate to) duplicate Dr. X's level of patience and honesty. What's most important about his example is that it encourages you to ask yourself, am I expressing as much patience as is needed in this situation? Am I being as transparent as this situation requires? While always open to learning from those ahead of us on the path, ultimately we have to find our own truth. What I admire about the way you approached this essay, --, is that is shows you are willing to question yourself and reconsider what you think you know about who you are. So long as this introspection and self-assessment is done with kindness

and compassion, it is an invaluable quality that will indeed enable you to keep learning and growing.

This is really impressive. I particularly liked your observation that Dr. X tried approaches "not in any textbook." What this means to me is that an outstanding doctor takes all the knowledge and skills she has developed, and then is willing to improvise further in the interests of the patient when it is apparent that more is needed. The ability to really try to enter in to the unique world of the patient and experience it through their eyes is one of the things that distinguishes a good from a great physician.

I agree with your conclusion, --. The need for this thoroughness was particularly evident in this case because of the patient's autism. But to some extent every patient's situation is different, and a tailored recovery plan that considers the patient's strengths and weaknesses in terms of following post-surgery instructions and rehab would I am sure enhance the success of the experience for all patients.

--, learning of the time and care this surgeon spent in trying to understand the unique situation of his patient was truly uplifting. I can only imagine how reassured the family felt that here was a doctor who understood the special needs of his patient, saw them not as an annoyance but as a critical and valuable part of his care, and plunged into problem-solving details to further the best interests of the patient.

I also really appreciated your observation about family and surgeon finding common ground (a successful recovery for the patient) and mutual respect by realizing how each party was working hard to achieve the best possible outcome. When the physician works respectfully, patiently, and diligently with everyone involved (medical team, family, patient), it can require a little more time upfront, but the results are many fewer problems down the road and satisfaction all the way around.

Good point. You can mirror the patient's emotions (which, if she's happy, is fine; but if she's anxious and tense, just intensifies the negative atmosphere); or you can project a different tone, which the patient may mirror (so if you are calm and confident, it makes it more likely that the patient will settle down and not be in panic mode).

Very well-observed encounter, --. You catalogued carefully the various behaviors of the neonatologist - sitting down, asking what the patient knew, tone of voice - that contributed to his successful interaction with this mom.

Your final point is particularly well-taken. When our mood does not reflect the somberness of a particular situation, it is usually because we are afraid to enter in to the sadness and distress of the family. Yet this is what empathy is, as you state in your final sentence. Learning to be present with sadness and suffering without necessarily trying to "transmute" it into cheerfulness and enthusiasm is a skill that can be developed if one is willing to take the risk. Expressing emotion appropriate to the situation is how doctors show their patients and family members that they care about their plight

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I'd like to believe that, if we think more broadly about the role of physicians as healers, these residents could have realized that although they could not save her life, they could have offered her their presence and their witnessing of the passing of her life. It takes great courage to face the end of life, especially in a young woman and a mother; but when the physicians demonstrate this courage, it helps the patient think that perhaps they can find their own courage.

--, I think what you did in this essay was describe some very human doctors, struggling to come to terms with a very tragic patient dying. As I read further, I could see that the team did a lot for this patient and family - controlling her pain with the help of a palliative care consult, supporting the family and finding resources for them, and giving the patient control over how she died. I still think that one of the most important lessons a physician can learn is how to be present with patients when they cannot "fix" or cure. There is still great therapeutic and human value in simply "being with" the patient, if only for a few minutes, affirming her personhood and value. Thank you for sharing this encounter, which was as complicated as most of life; and in the end showed people trying to do the right thing, and often, but not always, succeeding.

Beautiful. This physician's capacity to remain comfortable with his own uncertainty, even in the face of the patient's very understandable fear, is evidence of a truly skilled

physician. He realizes that rather than mirroring the patient's distress, he needs to be a calm and steady anchor in this situation. He is compassionate and tender, but he is not overwhelmed. What a great role model.

What impressed me here is how carefully you observed the subtle details of how Dr. X handled this very disappointing and scary situation. You realized that there were many steps Dr. X took (from spending time to being comfortable with silence while the patient processed to reaffirming his commitment to the patient and brainstorming some ideas for a way forward) that contributed to easing the patient's suffering. Dr. X was a great role model and you were a skilled and attentive learner

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As it should. Although thankfully the situation improved (and this may have been due to the resident's modulating his interaction with the patient), it would have been better if it had not happened at all. Although the patient's comment was provocative, it likely could have been deflected by a calm, even curious nondefensive response on the part of the resident. Although you can pull a nail out, it leaves a hole, so it is better not to drive it in, in the first place.

--, thank you for taking the time to share these two examples. You are quite right that both have something important to teach. You paid careful attention to what makes Dr. X an exceptional surgeon, and wanting to make your patients' faces glow when they see you is the first step toward making it happen!

In the latter example, you realize clearly that this resident got "hooked" by the patient's statement. Instead of de-escalating the patient's anger (in which I think we can hear a good measure of fear and exasperation), his actions egged on the patient and led to the totally inappropriate back-and-forth that you observed. As you express so well, it is always better to meet anger with patience, curiosity, and an open mind.

Also, in my view it is less than ideal to treat patients one way (kind and caring) and team members another way (impatient and brusque). Ideally, an exceptional doctor is the same person across all situations, and treats the frightened patient, the demanding family member, the burned-out nurse, the bewildered medical student all with the same forbearing and compassion. Of course, this individual would not only be an exceptional doctor, but also a saint, so perhaps that is asking a bit much! We all will fall short of our ideals, but the important thing is to 1) have them and 2) reflect

honestly on both our successes and our failures, so we can learn from them and continue to grow.

--, you learned a good lesson here. There are many physicians frustrated with the term "brain death," because for some families, it suggests a partial or reversible death. This is reinforced, as you astutely observed, by a lot of medical activity directed at the (now-deceased) patient. Coupled with the family's understandable denial, confusion can lead to unfounded hope. In the end, I think the family suffers more, because the loss of their loved one is compounded by suspicion that the hospital "let him die" or worse (observing an undesired/forced extubation and subsequent death has got to be extremely distressing).

The compassionate thing to do in such situations is to be honest - not brutally honest, but clear and straightforward, not offering loopholes the family will be only too eager to jump through. Delivering such terrible news in a way that is kind but unambiguous takes courage on the physician's part, but is really a kindness to the family.

--, you highlight important skills for every clinician - knowledge, skills, organizational abilities, and communication, not only with patients but with his team. Unfortunately, we have all seen examples of physicians who are good communicators with their patients, kind and compassionate, yet treat staff and students rudely, and are curt and demanding of their team. The ideal physician, in my view, is consistent across contexts - and can be patient and respectful with everyone who crosses her path, from the confused patient to the distraught family member to the exhausted nurse and the naïve medical student. It's lovely to hear that you are committed to being this kind of physician.

This is another very perceptive observation. A mentor of mine used to call it, "listening to the question behind the question." This is a real art, but it can be learned, especially by observing skilled role models. Sometimes patients can't, or are afraid, to ask some questions directly; so the physician must be sensitive to imagining what the patient might be wondering but is too fearful/ashamed/reluctant to ask.

I like this insight as well. Who you are as a physician should not repress or stifle your unique individuality. Rather, I think outstanding physicians filter their medical knowledge and skill THROUGH their personalities, so that patients see the doctor as a human being, just as the doctor sees them as a human being.

--, these are all well-observed and significant features of establishing rapport and connecting with patients. The first time I saw a physician crouching below a patient I was pleasantly surprised; but over the years I've seen many physicians who have learned or intuitively understand to position themselves below the patient. As you note, this definitely evens out the unequal power dynamic and helps to empower the patient. Being yourself, expressing emotion, sharing humor, listening for the questions NOT asked, and other approaches you mention al serve to set the patient at ease and make them feel more "at home," an admirable goal we should try to achieve for all patients.

Unfortunately, you are right, --. I wish there was a magic bullet for guaranteeing that by practicing good communication and demonstrating empathy all patients and families would become kind and cooperative in return. Sadly, not all will, although I do think that such behavior increases the likelihood of a positive outcome. So you are right that rapport cannot always be established and connection cannot always be made. What I'd invite you to consider is whether, in addition to delivering the best possible medical care, it can be possible to still care about, even "love" that difficult, horrible, nasty patient and family? Is it possible to see past their unfair anger and abuse to their broken-heartedness, fear, and suffering? This doesn't mean in any way changing your appropriate medical plan, but it might mean being able to spend more time with the patient without dreading each encounter. To be honest, based on my own experience (which is not clinical), this is easy to describe but very hard to do. When I am able to be more centered and "loving" toward someone who opposes me, I find more peace personally and sometimes (not all the time!) our interaction softens just a bit.

--, your team sounded magnificent. You could tell right from the start that it was going to be very challenging to keep this case on track. Patient and family were just itching to explode - and eventually despite your best efforts, they did, and the situation really deteriorated.

I loved what your intern said. I would engrave that in your heart - or put it in your iPhone. "The mean ones" are the real test of our empathy and compassion. And often, at least based on my own experience, we fail.

Nevertheless, I love these encounters with "the mean ones" because each time is an opportunity to practice a different way of responding - a way that is more compassionate, more loving, less reactive to their anger and rage. When I can achieve a calm, centered, and kind demeanor, when I can choose not to be angry or hostile back just because that is what I'm receiving, I feel less stressed and sometimes the interaction even goes better (not always). Just something to think about!

--, this is really good self-awareness. Many doctors have high control needs, which in part helps them be good physicians, because they like to take charge and run things. But there are also times in medicine when the physician needs to relinquish some measure of control, and teaching, as you point out, is one of them. Becoming the best doctor you can be starts with self-awareness. Acknowledging that letting go of control can be challenging for you goes a long way toward working with this tendency in ways that will benefit your future students/learners and even on occasion your patients.

--, it sounds as though you chose a superb physician role-model to shadow and reflect on. Your observations are really excellent and show evidence of careful analysis as to why Dr. X is so comforting and calming.I'm impressed with your ability to recognize your own need for control (up to a point, a good thing in a doctor) and analyze how it could become a problem in teaching inexperienced learners. I agree with you that, by holding the image of Dr. X in your mind, you will be more likely to allow your future students greater latitude as a teacher, while still providing scrupulous supervision.

Finally, I'm so glad that from this shadowing experience you re-appreciated the important role that caring, compassion, and communication play in good doctoring.

I agree, this is an awesome response. It is grounded in humility and uncertainty. The doctor says in effect, "I am not God. I can tell you what I know, and what I

understand it to mean. There is a lot in heaven and earth no one knows, me included. And so let's wait together and hope together and see what happens." This response took a lot of courage.

Thank you for sharing this very powerful interaction, --. I admire that this physician was absolutely honest in what she knew and what she expected, while also acknowledging the limits of her certainty and allowing for something unexpected to occur. She is moving the family toward hope within the context of realism. She is allowing them the additional time of "day by day" until there is more certainty for everyone. This is laying the groundwork for a poor outcome while acknowledging a place for hope.

Fascinating - and disappointing. Clearly from your description this resident conducted herself extremely well with the patient. Yet apparently the emotional cost was so high for the resident that she needed to vent her frustrations in this xenophobic remark. We can be thankful that her professionalism did not permit her to show her disdain directly toward the patient. Yet one might hope that the next stage in her development would include congratulating herself on her kind, professional care of this elderly woman and feeling grateful that she was available to help her.

All we know for sure is that there is a contradiction between the resident's behavior with the patient (superb) and her judgmental commentary in your presence (disappointing). She may hold certain political beliefs yet have been moved by the plight of this individual patient to treat her with compassion. She may have stuffed her real feelings and "faked" compassion. She may have been sincere in her behavior, yet so stressed and burned-out that she needed to vent, and the patient's lack of English was the nearest target. Regardless, you are correct that such a statement shows a failure of understanding anything about the immigrant experience, and someone who longs for simple solutions to complex problems.

--, this is a great example of an imperfect person struggling to do the right thing in one instance and indulging her lower impulses in another. We can be grateful that at least with the patient she conducted herself professionally and caringly and as such was a great role model for her medical student. It is very disheartening that, in a more private context, she modeled xenophobic, nativist attitudes for the same

student. The goal for all of us is to align with our higher values so that, regardless of setting, we are the same person. This is hard to do, but I hope that resident went home and was a little ashamed of the statement she made in front of you. With this kind of self-awareness, she could then forgive herself for an unskillful comment, and vow to do a bit better with her next student.

--, this was a relatively gentle introduction to the difficult but essential art of "bringing" bad news. Dr. X is a great role model, a compassionate and patient physician who can be fully present even in such challenging circumstances.

You make an interesting point about never making assumptions about how patients will react to hearing bad news. One caution to keep in mind - some people are "hot reactors" and instantly dissolve in tears or start to rage. Others need time to process the information, and initially may appear quite calm and accepting, only to become fearful or despairing later. So while it is very valuable to note the patient's first reaction, as you did, it is worthwhile to check back to see how they are coping the next day.

--, thanks for such a careful observation of this anesthesiologist. You highlighted many important aspects of good doctoring - managing expectations, making a personal connection, using humor appropriately, reading patient emotions, and being willing to show one's own humanity. Watching a skilled physician translate these abstractions into bedside behavior and learning from this is I think the best and most memorable way of learning to become a great doctor.

Thank you for paying attention to this small but essential moment in the life of this patient. At a point when she was vulnerable and alone, she found a doctor who was there for her emotionally as well as medically. Not everyone would have appreciated the significance of this exchange, and I'm so glad you did. Such unexpected moments offer an opportunity to be fully present with patients. If you are relying on routine to carry you through, you will not be able to understand, much less meet, the patient's needs. This resident had the emotional (and linguistic) skills to change course on a dime, and realize that there was a new presenting problem in the room. I hope you

can fix an image of this compassionate resident and grateful patient in your mind, to draw on whenever you feel busy and overwhelmed. It can provide you with an important anchor moment about what truly matters in medicine.

--, thank you for this observation. You did an excellent job of identifying the underlying qualities that made this attending's patients so happy to see him. He was genuinely glad to see them, and sincerely interested in them as people. As you point out well, these are qualities that can transfer even to a busy ER. I really like you concept of "welcome." If you think about the standard ER, I don't know how many of the patients waiting to be seen, or stuck in the curtained cubicles, actually feels "welcome" or cared about. It's hard to convey this sense but if you heard Dr. X's presentation, you will remember little ways that she put patients at ease as much as possible. You are absolutely right that you can set the tone (not completely, but in important ways) with the patient. By not reacting reflexively, but taking a breath and choosing the most caring, thoughtful response, even in the ED, where things are often more intense than plastics, you will be able to achieve at least a grin or two - maybe even a hug if you're lucky - from grateful patients :-)

Absolutely correct. The physician's reliance on complex medical terms, without translating them into more comprehensible ordinary language, put both interpreter and patient at a disadvantage. Although medical interpreters are supposed to be conversant with medical terminology, it is the physician's responsibility to reframe their thoughts into easily graspable language.

Thank you! These are exactly the questions you should ask yourself before each patient encounter: What is most important for the patient to understand from her perspective? And what is most essential for her to understand clearly and unequivocally? The answers to these questions will help guide your interaction in fruitful and meaningful ways.

--, thank you for this balanced appraisal of the physician's interaction with the patient. I agree that often busy physicians try to short-cut use of interpreters, and it is also admirable when a physician takes time to engage in a complex conversation. But you are also absolutely right that it is the physician's responsibility, NOT the interpreters, to ensure true patient understanding. Clearly that was not the case here.

As you point out, with some care and effort, such a situation is largely avoidable. By adapting her language (thinking more carefully what she wanted to say and how she chose to say it to the patient), the physician could have increased the likelihood of achieving at least a higher level of comprehension. Your final two questions are superb - if you always ask yourself 1) what does the patient need from this interaction? and 2) what is essential for the patient to truly understand? - then you will be doing a great service to your patients by ensuring that they are truly understand the decisions they are making.

Thank you, --, for getting in this essay. I recently read a really good book, In Shock, by a physician who becomes gravely ill and what she learned from it. At one point she says, Doctors spend their lives with their backs toward the abyss, watching as their patients run toward it, and trying desperately to catch them, and throw them a few feet back. This is an important endeavor. But sometimes it is import to face the same way as their patients, to look into the abyss, and if necessary, to stand beside them as they fall over. I think that is what your Neuro ICU doctor was doing - standing beside the family, looking with them into their abyss.

--, this was the most unusual example of a physician role-model I have ever read. Yet as soon as I saw the pathologist's quote, I realized that a kind of "relationship" or at least commitment can exist between the living and the dead. I also understood your point that seeing this body and the effects of disease on vital organs could deepen your determination to help the living. This was an original and interesting choice, --, and I learned a lot from it.

--, this is an excellent analysis of the people skills needed in anesthesiology. As you have no doubt noticed, there are many impressively humanistic people who've chosen this specialty. You state very well that anesthesiology requires a good doctor-patient relationship, it just looks different from the relationship in a primary care setting.

--, I appreciated your comparative approach in assessing the resident and the attending. I also liked that you were careful not to condemn the resident by

imagining the possible stresses or strains this person might be undergoing. At the same time, you were able to discriminate the subtle yet significant differences between the two and to recognize that these differences might make the difference between a good and a great doctor.

I also very much liked your comments about the kind of doctor-patient relationship necessary in anesthesiology. I agree completely that anesthesiologists, not unlike ER docs, need to know how to establish rapport quickly, allay fears, provide clear explanations to resolve confusion, and in a few minutes create a context of trust that allows the patient to trust you even when unconscious. That, I think, is a special kind of trust.

Yes you can. It is important to look for creative solutions, as this physician obviously has; and it is important to set boundaries (on both family and work) and learn to say know in a loving yet clear way. Be on the look-out for role models who've learned to do this; and they will give you the strength and the confidence to do this in your own life.

Dear --, as I mentioned, you are the first person in class to note successful work/life balance as something worth emulating. I'm so glad you chose to focus on this dimension. Of course this is extremely important, and sometimes it can be discouraging to see so many physicians whose lives are still very much out of balance in favor of work. Yet, increasingly, you can find physicians who are successfully managing both roles. Learn from them, observe them, ask them questions. This should not be an impossible goal. You should not have to sacrifice family for medicine. Know what you need to be happy and fulfilled as a doctor and a person; and then be steadfast in pursuing that vision.

--, I'm delighted that before you leave UCI you had this corrective experience of bedside rounds. You did an excellent job of closely observing why, in contrast to other bedside rounds in which you've participated, these were a positive experience for patients, families, and team. I particularly liked your awareness that a good bedside rounds should include the patient but should not overwhelm or frighten them.

I was not familiar with the study Dr. X cited, but I'm not surprised. Like you, I've observed more than a few bedside rounds that, from the patient's perspective, are confusing or alarming. But as you saw, done skillfully they can provide patients and families with a sense of inclusion. I am reminded of the old rallying cry of persons with disabilities "Nothing about us without us!" Bedside rounds require the ability to identify and address multiple priorities, as well as to read and process the needs and emotions of a diverse "audience." They're hard, but as you learned, they can be very valuable.

--, thank you for your close observation of Dr. X. You did an excellent job of noting some of the specifics that make patients feel he is the best doctor they've ever had: his calm demeanor, his knowledge of the person of the patient, his thorough explanations, and his eagerness to ensure that his patients actually understand what he has told them. It is when you start to break down that feeling of "awesomeness" that you can begin to see how you can become the doctor you admire!

I am so glad to learn that as someone going into surgery, you've realized that surgical skill and humanistic attitudes are not opposed. I've always felt the stereotype of the brilliant but callous surgeon is letting the specialty off the hook. Surgery allows its practitioner perhaps the greatest intimacy with another's body - for goodness sakes', your hands are inside another's body! Out of this can come great wonder, awe, humility, and a deep commitment to the person of the patient. True, the surgeon can regard herself as a high-level technician, but I think this is missing out on other dimensions of "knowing" others that perhaps only the surgeon has access to. Some of the greatest humanists I have either admired or known have been surgeons. It's nice to know you will be another.

Dear --, I hope you do not give up on your vision of how healthcare should be practiced not only in specialty but also in primary care settings. I think that, at least at the moment, you are right - the only way to get the kind of in-depth time you crave with patients is through a concierge practice. However, there are lots of different models for these types of practice so that although they do promote two-tier medicine there are ways of ameliorating the inequities. It also depends on how much

debt you are carrying after medical school and residency; and what kind of lifestyle you are hoping to achieve. My main point is that it is not naïve to want to practice attentive, caring, and conscientious medicine.

Your write-up of this encounter shows admirable attention to the process details of this encounter. You paid attention to small but essential nuances that can make or break an interaction: listening "intently"; asking a question "in a kind way"; realizing you are making an assumption about a patient's knowledge. Your thoughtful reflections I hope will make it more likely that the next time you are with a patient, you will ask yourself not only am I listening, but am I listening intently; not only am I asking the right questions, but am I asking them kindly?
