AoD 2018-2019 ASSIGN 1

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Dear --, this was an interesting situation which I've never heard of before but which I imagine will be increasingly common. I think you are right to be able to set limits on anything that will potentially impede your care of your patient.

One of the most interesting aspects of this incident was your initial willingness to "let their shenanigans slide" because the men filming were close to you in age. This illustrates how idiosyncratic factors can influence our decisions for better or worse. Perhaps the age similarity made their behavior seem harmless, something all young people do (i.e., record every moment of their lives). Perhaps you might have unconsciously wanted to be "one of the group," just a hip guy rather than a medical authority figure.

One additional twist to consider is that being similar in age to these men may have made it easier for them to relate to you and respond positively to your request; whereas with their own transference issues, they might have seen an older physician as too much of a father figure, and rebelled against his request.

In any case, one thing that can be learned is the way in which transference and countertransference can affect our interpersonal interactions. This awareness can guide your choices, as it did in your case. Ultimately you decided, wisely in my view, to use your white-coat authority to put the patient's needs front and center, even if this meant restricting the filmic activities of his drunk friends. You chose to be a doctor.

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--, it looks to me like you are going to be a stellar pediatrician. Your first example illustrates your skill in working with a parent who might have been labeled demanding and difficult. With patience, respect, and giving her an active voice in her kid's care, you were able to successfully enlist her. You built rapport and trust and at the end of the hospitalization she was grateful. Everyone - the patient, the mom,the med student, and the team - benefited from your approach.

In the second example, you were able to transform a scared kid into a happy, excited one by emphasizing her humanity. In these extra interactions, you recognized her as a kid, not a patient. As a result, her fear dissipated, and I'm sure this made it easier to take care of her.

I'm sure you've noticed that while almost all pediatricians love kids, some seem to regard parents as inconveniences or obstacles. The great ones, however, know they are really caring for the parents as well as the child, and have the patience and skills to earn parents' trust and give them space to be involved. You seem to already understand this very well.

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Dear --, there were so many challenges with this patient (and such tragedy - as you point out, this situation should have been preventable). What impressed me was that, despite the interpersonal difficulties you encountered with this patient, you persevered, won her trust, and ended up finding the "root" of why she was so adamantly opposed to conventional medical treatment. It is not completely surprising that, given the strength of her feelings and the lateness of any possible intervention, you were not able to persuade her to consider conventional treatment. Yet, although understandably distressing, I do not regard this outcome as a failure. You understood your patient's thinking and she had a chance to revisit it in a more critical way. She made a choice ...which is not the choice you hoped for, but at least you gave her the opportunity to think through her position in your compassionate presence, knowing you had a very different perspective.

Your conclusion is really the right one, as far as I'm concerned. If you understand what is driving a patient's thought-process and behavior, you might be able to influence it in some way. This is not always possible, but without such understanding you are unlikely to get anywhere. Excellent work, --!

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--, your approach to this patient was awesome! It was original and empathic. I loved the way you helped counteract the public images of mental illness with another celebrity image. Inspired! It was also clear that you came up with this approach by knowing your patient well and knowing what might be persuasive to him. Again, wonderful.

Although it probably took you a bit longer to think about how to present this diagnosis, and additional time to find an appropriate role model with mental illness, in the end you saved your patient and yourself much grief and difficulty in navigating denial, anger, despair etc. all of which would have been likely outcomes of a less thoughtful approach. Once again we see that a little care at the front end can save many complications down the road. Well done!

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--, this encounter was certainly difficult, perhaps frustrating, but also, as you say, full of important clinical lessons. It can be unbelievably hard for patients to face their own mortality. This may lead to nonadherence, inconsistent follow-up, and "denial." Although such reactions complicate medical care, they are so understandable. Who wants to accept their cancer is back, and that treatment will involve bone marrow transplant? Not many of us.

The approach you describe offers the best chance that your patient will come around and you will be able to do what you can to help him: patience combined with gentle persistence. You did not allow your patient to seek refuge in denial, but you also recognized what a terrible struggle it was for him to face the reality of his situation.

As you note, one of the most challenging aspects of serious illness is that it disrupts our desired life story, the one we are pursuing and the one we've chosen. Sometimes it breaks this story permanently. This leas to intense feelings of helplessness and loss of control. Often the only thing that the patient still can control is refusing treatment, refusing to accept the diagnosis. Recognizing these dynamics, as you did, can help the patient come to terms with what he must, and then the team can do what it can.

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--, I learned something from the way your attending handled the patient's yelling. By acknowledging the patient's pain while assuming he would not punish the physicians trying to help him, the attending appealed to his better nature and (subtly) called attention to his inappropriate behavior. I hope it had the desired effect of tamping down his aggressiveness. A good rule in interpersonal interactions is to begin by using the least amount of firmness you believe necessary to accomplish your goal. It is always possible to increase firmness if the patient does not respond. In this case, the

attending sent your patient a message without overtly confronting him. This seems to me a very good way to try to contain the situation.

I am also impressed that you noticed this comment and hopefully the ameliorating effect it had on the patient. To learn from good role models we have to be paying attention to what it is that they do so well.

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Dear --, it sounds like you tried very hard to connect with and support this patient. In a way, your hands were tied. Patient and family were convinced that the person with the answers was the attending; thus anything that you (or resident or even fellow) said could be ignored. The attending sounds exasperated and avoidant. Maybe he felt guilty that the patient's cancer have recurred. To me, it sounds like he'd severed his emotional connection with his patient ("this is her pattern"). Thus the one person who could really have helped her see the gravity of her situation had stepped back, maybe without his even being aware of this withdrawal.

Working with patients so that they can grasp their often devastating circumstances involves emotional labor on the part of the physician. This heavy lifting is not easy, but it is part of what it means to be a physician. As you recognize, it is a responsibility where the primary physician must lead. He or she does not have to carry this burden alone, but it cannot be shirked either. Paradoxically, when there is greater clarity, there is undeniably great grief, but also often some relief.

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--, I was really impressed by your essay. First you showed admirable self-awareness and honesty, recognizing feelings of anger, pride, and potentially guilt and lack of fulfillment. These are, of course, normal feelings, but they can weigh down our souls and compromise our ability to extend compassion and caring toward others. By pausing, taking a breath, and reevaluating your initial response, you were able to release (at least to some extent) the anger, and recalibrate to prioritize the centrality of your patient.

The other aspect of the essay that I thought was significant is that your wonderfully restrained and kind behavior didn't "work," at least not in the sense of transforming your patient into a grateful, cooperative person. Eventually he was discharged for

continuing his verbal abuse of staff. Managing your own problematic responses to others is not a magic pill, and cannot always repair all the difficulties, challenges, and suffering your patients have experienced in their lives. But, at least in my experience, by behaving as you'd like to behave (how perhaps your role model would behave in a similar situation), by responding thoughtfully rather than reactively, you free yourself from the burden of knowing you could have behaved better, and you gave the patient the gift of recognizing his humanity. People don't always accept the gifts they are given.

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--, you learned exactly the right lessons from Dr. X and your encounter with these parents. Many, perhaps most, patients and families have somewhat to very unrealistic expectations of what medicine can and cannot do. This is really a cultural problem, the result of many factors, and not the "fault" of ignorant patients/parents or arrogant physicians. The "solution," as Dr. X demonstrated so well, is patience, honesty, clarity, and compassion. Helping these parents adjust to the reality of their child's circumstance required more than one conversation; in fact it required constant reiteration. But this kind of evolving education helped parents adjust to the reality of their kid's situation; and likely saved you even more difficulties with the parents. The understanding and skills you acquired through the care of this patient and his parents will be useful over and over again in your career as a physician.

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Dear --, I can hear some lingering regret over your decision not to explore with your attending her decision to institute TPN for this patient (and fortunately, as you say, no harm was done). In the hierarchy of medicine, speaking out is made very difficult. The top leads and the bottom follows. And "choose your battles" has some utility: you cannot always be fighting on all fronts. But the interesting assumption here is that expressing a difference of opinion or asking a question is inevitably a war zone. Of course, many physicians see it as such; but it doesn't need to be the case. Learning how to respectfully question a course of action ("help me understand the thinking here") or express a different view ("I follow your thinking, and it makes sense, but I'm wondering about this...") can minimize the chances of a battle. There are lots of fragile egos in medicine and you will probably break a few by speaking up, but you may also better protect and care for your patients by doing so. As your residents well knew, it's a balance. My advice is to speak up when you can, and to learn from those

situations where you cannot. Owning your voice is important in medicine - and in life :-).

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--, thank you for sharing so openly about your travails as a minority, female medical student. It was painful for me to realize that, on top of all the stresses and pressures of medical school, you have to endure and struggle with discriminatory assumptions and behaviors which, understandably, can make you doubt yourself. You so "deserve" to be here, which a part of you knows. You worked hard and you earned your spot. But it is hard to hold onto that truth, especially when there are many incidents and attitudes that can tear you down. The key, I think, is to hold fast to your belonging, even if not everyone recognizes it, and find support from people who understand what you are going through and can validate your presence.

I regret deeply that you must go through these doubts and uncertainties, which are not your responsibility, but the responsibility of a society that is increasingly racist, misogynistic, classist, and xenophobic. You are a pioneer, and right now must absorb some of the difficulties that go along with that. I am so sorry that is the case, and I hope you can find the inner and outer resources to make this journey a little easier. I pray you are building a world where a little kid in Santa Ana looks at you and says, I'm smart and like to help people, I'm going to be a doctor just like Dr. X.

I have not walked in your shoes, --, but if you'd ever like to talk about this further, please just let me know.

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--, this sounds like a very difficult situation. In my view, you made the right call, even if it resulted in a breach in the relationship with your research advisor. I agree that when possible it is ideal to be able to choose compatible supervisors and colleagues. Unfortunately, as you know, this is not always possible.

The next line of defense is to anticipate difficulties (such as research not progressing in line with a clinical schedule) and problem-solve contingencies in advance. When there are interpersonal difficulties, making everything as clear as possible (if A then B) in advance can sometimes mitigate problems.

Finally, as you discovered, at times you have to decide what is the right thing to do, and then have the courage to speak out, even when you have less objective power. You did just that, and I think this is quite admirable.

I hope you were able to complete your research without further complications. In the end you have the satisfaction of knowing that you behaved in a patient-centered, team-centered way.

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--, this is a beautifully written and, more importantly, beautifully perceived essay. I actually would encourage you to submit it somewhere like JAMA's A Piece of My Mind.

People are pretty complicated, and usually they are not just one thing or the other. You are so right that our expectations and our own behaviors in the healthcare system often push patients into boxes. When we listen, when we are respectful, and as you demonstrated so well, when we are willing to align ourselves with patients (not necessarily acceding to all their desires, but finding a common goal, such as you did), often good things happen. I am so glad that was the case here; and beyond that, I'm so glad you still remember this patient with gratitude.

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--, this example illustrates that seemingly "difficult" patients almost always have a logic to their demanding, irrational, or otherwise problematic behavior. You showed considerable skill in eliciting this patient's existential fear, especially in the chaos of an ED setting. You also realized that contact with the cardiologist in the patient's mind reassured him he was not facing imminent death. By integrating this contact into the work-up plan you negotiated, you successfully met his needs while also providing him with the evaluation he needed. The result was a "transformation" from an irascible, uncooperative patient to one who was pleasant, even accommodating. When you made the decision to elicit the story behind the patient's frustrating behavior, you avoided escalating conflict and were able to provide the care this patient needed. Well done!

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--, thank you for this reflection on the difficulties of cross-language medical interactions. Being bilingual (as I infer from your essay), you are already well-positioned to reduce the number of interpreted encounters you experience. But in our diverse society, everyone will run into language differences at some point, so in a way it is good you had this experience.

You learned many important lessons, including 1) choosing your language carefully and intentionally, rather than relying on the interpreter to sort out what you mean 2) paying attention to body language and especially tone of voice. Your attending to both of these issues contributed to a positive outcome in which your patient and her spouse actually felt secure and heard in this encounter. Nice work!

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--, thank you for writing so honestly about this very difficult situation. From what you described, the attending took a very un-patient-centered approach, and then forced you to deal with the consequences. Understandably, you were very concerned that suturing a screaming, poorly anesthetized 3 yr old might have resulted in a less than optimal result that would haunt this child throughout her life.

I agree with you it is so hard to speak up in the medical world - there is hierarchy, there is tradition, there are many sensitive egos. Still, I hope that as you work your way up that hierarchy, you will consider speaking up sometimes under conditions that make you uncomfortable. This attending might have eaten you for lunch, but maybe another time the attending will consider your perspective. In medicine, challenging authority is never done lightly, but sometimes it should be done, and there are ways of starting a dialogue that can mitigate the defensiveness and annoyance such challenges can trigger.

In the related scenario, as you proceed through your career, you will as you observe encounter poor physicians. Each situation is unique, but again there may be times when silence is not in the best interest of either the offending doctor or his/her patients. You will inevitably acquire more authority and status, and it is worth considering how you will use them.

That said, these are complex decisions, and you are the only one who can make them. I hear your love of medicine and your commitment to treat it with respect. I know you will be thinking in these future situations about how to do the right thing (or the

closest approximation thereof) in ways that honor your patients, the profession, and yourself.

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--, this case reminds me how important it is to understand patients' motivations, circumstances, and resources; and to be curious about things that don't add up. In this case, there is a gap between the patient's obvious desire to be relieved of hernia-related distress and his inability to comply with a medical regimen to prepare him for surgery. So many questions - Does he have financial constraints? Does he have cognitive limitations? Does he lack a support system? Does he disbelief his diagnosis of hypertension (with likely no symptoms) vs. his painful awareness of the inguinal hernias?

It sounded to me as though the team realized that the approach taken over the past several years (prescribe medication and instruct patient to take it) was ineffective. You know the definition of insanity...
Instead, the team tried to fill in some of the gaps that had emerged previously by linking the patient with his pcp and a social worker. Hopefully this will make a difference.

As you say so well, it is the physician's responsibility to do what is in the best interest of the patient even in situations of limited internal and external resources. It is important to do so without blaming the patient for his straitened circumstances. Your patient is suffering and your goal is to help relieve the suffering, while accepting that your interventions may fall short and may not result in the desired outcome. This is a hard lesson, but an essential one. It will be easier for you to look yourself in the mirror when you can say you did all you could.

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I was struck by two aspects of your essay, --. The first was that you (and the team) recognized that establishing trust with this patient required first and foremost just listening to him. People want to be seen and heard, especially when they've undergone what they perceive traumatic and poor care. By listening to their story, you show the you hear their perspective and that you care.

The second thing that struck me was the patient's expressing gratitude for being seen and heard by the team. People only express this sort of gratitude when they feel strongly. For me, the patient's response reinforces the importance of seeing the doctor-patient exchange not only as a transmission of information from doctor to patient but as an encounter between two human beings whose goal is to reduce the suffering pf one through the expertise, skill, and compassion of the other. It sounds as though you and your team were able to do this even under difficult circumstances.

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--, you reached a good resolution of this incident. Initially, and very understandably, you experienced "discomfort, guilt, disappointment, and hopeless" in response to this patient's rejection. However, upon reflection, you discovered two important lessons: 1) It is usually not about you 2) Despite the difficulties, it is indeed a privilege to care for those who are sick and suffering.
The first step in managing your own emotions in a room full of emotions is to be aware of them, as you were. The second step is to reframe, and take a different perspective - which you did. Otherwise it is easy for your emotions to "parallel" those of the patient (i.e., the patient feels discomfort, you feel discomfort; the patient is frustrated, you are frustrated; the patient is angry, you are angry) in ways that will interfere with the patient's care. When you realize this isn't personal, but an outgrowth of the patient's distress, instead of being directed by the natural negative emotions that arise, you may actually begin to feel genuine gratitude for the opportunity to care for the patient; and genuine compassion in the face of their suffering, regardless of how they are behaving toward you. This doesn't mean that you shouldn't set limits on abuse behavior that crosses a line, but it does mean that by exercising emotional self-regulation as you did that you can maintain a patient-centered attitude.

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Dear --, thank you so much for this incredibly honest essay. What I'd like to address is the guilt and regret you felt that you did not "speak up" to urge the team to help the patient understand that, indeed, she was near death, and that further diagnostic work-ups would not change the course of her disease. You sensed in your gut what needed to happen, but you did not have the knowledge or skills at the time to make it happen. I am not sure that you could have affected the situation or the behavior of your attendings and residents, although you might have felt better if you'd made an

effort. This may have been a mistake, or it may have been the inevitable consequence for a beginning third year student placed in a very difficult and bewildering situation.

Even if it was an error, in my view given all the mitigating circumstances of your lack of knowledge, lack of experience, lack of understanding of "how things were done," it was a very small one. By far the greater error lies at the feet of residents and physicians who have been in this situation many times before, and have not yet come to terms with the limits of medicine and the approaching deaths of patients. Your unswerving self-examination and commitment to do better puts your superiors to shame.

--, I hope you have forgiven yourself for the way this situation unfolded. I hope in your heart you have been able to ask forgiveness from the patient and her family and have thanked her for the gift she gave you of awareness and understanding. From her you learned a lesson many physicians never dare to learn - patients deserve honesty delivered with compassion and caring. I admire your courage in accepting this lesson. You will always remember this patient, and remembering her will make you a better doctor. She has already made you a better doctor.

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--, this is a humbling example of what can happen when physicians too quickly categorize a patient, especially a patient they find annoying, demanding, "drug-seeking." These labels allow the physician to dismiss the patient, and stop searching for answers. It sounds as though you were the person on the team that, despite the patient's bad behavior, continued to think about the patient's plight, continued to consider whether, despite the BPD and demands for pain meds, there might be something more going on. I find this a very admirable quality: just because the patient "gave up" on her medical team, seeing them as the enemy, you did not give up on her. Instead, you continued to wonder about the symptoms she presented and their meaning. In the end, you discovered that at least part of her problems were related to a treatable condition. This patient was lucky to have your doctor; and you were lucky that you learned a valuable lesson about trusting your patients, even when they are annoying and frustrating.

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Dear --, I'm sorry you had to endure the anger of your patient's husband, especially when you clearly made such an effort to be a good listener and communicator. Nevertheless, the conclusions you reach are exactly the right ones. Usually, althoughnot always, the patient's/family member's outburst is not about you, it is about their helplessness and loss of control about their situation. Knowing this can help you remain open and compassionate in the face of their suffering. When you have done all you can (as you did in this case), while it is natural to feel disappointed that you wee not able to transform the situation, you can take some consolation in the fact that if you had not been able to retain your composure, the situation might easily have escalated into something much worse. In this case, the husband was not able to respond in real time to your kindness and care. It took him a couple of days but he got there. It can help to hope that eventually most people will get to where they need to be. In the meantime, we must be patient.

Finally, I admire that in a difficult situation where you weren't sure how best to proceed, you called in back-up. I hope this is something you will always be able to do, no matter how experienced you become as a physician. Many situations of uncertainty can benefit from other perspectives; and as you recognized, the criterion should always be keeping the welfare of the patient front and center.

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What an excellent and generous essay, --! I particularly appreciated the way you compared and contrasted your 3rd year you and who you are now. It is wonderful to see your growth and self-awareness. There is no question this was a very frustrating situation. All the time and care that was spent on the family conference was undermined by mom caving in the face of her daughter's anger at remaining hospitalized. You'd hoped to move things forward (one more problem solved and off my plate) and instead you were back at the beginning. The interesting question becomes, where do we go from here?

Blaming/judging patient/family is natural because it puts the responsibility for the difficulty outside yourself. Understanding (while not agreeing with) the mom's change of heart shows a way forward. Empathizing with her distress while reminding her of her goal to do the right thing for her child is likely to lead to a good outcome. By examining your own feelings you decrease the chance that frustration and irritation will drive what happens next. By taking a step back, realizing this is not primarily about you and imagining the mom's perspective, you discover a way to

maintain (and even deepen) the relationship while continuing to work toward resolving the issue. As you imply so wisely, things do not always proceed on the hospital's timetable. People are not machines, and thus may panic, reverse course, or hesitate. This is okay (in most cases), and simply invites more discussion.

It is very encouraging to see you have so much understanding of these dynamics as a 4th year student. This will stand you in good stead as an intern and really throughout your career in medicine.

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--, I am puzzled by what went wrong in the first place between patient and team. Was it a case of the patient being reluctant to describe the intensity of her pain? It sounded as though the fellow was very willing to manage her pain appropriately. In any case, the team did an excellent job of owning the problem. A sincere act of contrition involves taking responsibility for your part, apologizing sincerely, and doing what you can to remedy the harm. The team did all of these things, and fortunately were able to regain the patient's trust.

An old Buddhist saying observes, when you drive a nail into a piece of wood, you can pull it out, but it leaves a hole. Better not to drive the nail into the wood in the first place. If possible, anticipating problems leads to easier solutions. When this cannot happen, making amends directly, exactly as happened here, is the best way to repair and move forward.

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Dear --, Dr. X is such a compassionate and skillful physician, it is wonderful that you had the opportunity to work with and learn from him. I am impressed at how carefully you paid attention to this important yet painful interaction - it would have been easy to "check out," and leave it in Dr. X's capable hands. The insights you had about WHY Dr. X was so effective with this family and HOW he helped them navigate one of the worst moments in their lives are key to learning how to be fully present in the face of suffering as variously a witness and a guide. Learning how to face such situations rather than run away from them (if only emotionally) will stand you in good stead as inevitably you encounter suffering, death and dying in medicine - and life. You did not say this explicitly, but I think one thing Dr. X knows how to do is "contain" the suffering of others. He empathizes, but he is not devastated by

their pain, which means that his presence makes the suffering family feel a bit safer in their grief.

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In my view, curiosity is one of the most valuable attributes a physician can possess. Sometimes it is much easier to experience curiosity than empathy, but I have discovered that being curious/interested about a patient almost always leads to deeper understanding, which usually results in greater empathy and compassion.

Part of me is sorry to learn of this “regression” in the relationship; and part of me is glad you had this experience, because the relationship between listening to the patient/appreciating their perspective and improved interactions is usually not linear. It proceeds by fits and starts, and can run into additional obstacles.

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--, although this story is indeed heartbreaking, I was lifted up by the hard emotional labor the entire team did in staying present with the family, not escalating the conflict, being patient, listening, acknowledging their grief, and always being focused on the best option for the suffering patient. Even at this dire point, you all had something important to offer the patient, and that is what you did. Job well done.

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--, you raise one of the thorniest issues in medicine: what is true autonomy, which we define as the first among equals of ethical principles guiding the practice of medicine. Degrees of freedom are often interdependent with structural inequalities. Is it the case that the patient "chooses" dialysis, cardiovascular disease, stroke, peripheral neuropathy in order to avoid diarrhea? Of course not. But given consequences down the road tht are hard to envision vs. daily discomfort and embarrassment from diarrhea, does she choose to stop taking the drug causing her misery? Yes. This patient may feel she has little choice. And of course a simple solution exists - other medication. But because she lacks adequate resources, this solution is not available to her. The patient becomes noncompliant.

I commend the fact that you and the attending persisted in pursuing possible insurance options as well as monitoring the patient more closely. As her health is adversely impacted by her lack of medication, she may reconsider. You were

definitely continuing to help in the only ways available. But it is worth considering whether as a society we should really force people make such choices.

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--, you had such a valuable experience in being able to care for this patient while on both the primary and consulting teams; and it sounds as though you learned a great deal from your experience. The whole situation sounds heartbreaking, especially the young age of this patient and the fact she had a young child. Unfortunately, it appears that the conflicts and disagreements among the primary and consulting teams only added to the confusion and distress of the family. It's not that anyone is being a "bad doctor" but I've noticed especially among consulting specialists that there can be an unwillingness to consider the "larger perspective." Yes, the kidney function can be fixed, but is this really relevant when the patient is very likely going to die? I have witnessed to me tragic interactions where the doctors are explaining to the family that this or that can improve, and the family is desperately agreeing, while no one is willing to say, ultimately this "fix" is not going to make any difference in the overall picture.

Your experience over time and on different services with the same patient convinced you of the criticality of specialists learning to listen to each other with respect; having the courage to look at the big picture; and then presenting a single, clear message to the family and patient. When doctors disagree, patients and families will usually go with the one who gives them most hope. When unfounded, this hope can be cruel and lead to wasting precious time for patient and family.

--, I'm confident that your insights will make you pay special attention to your communications with colleagues whether from the consult or the primary perspective. Realizing this is going to contribute to your skill and compassion as a physician.

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--, this case illustrates the importance of not reacting reflexively to annoying demanding behavior in patient or family. There is always a "reason" for the difficulty, even if it is not a reason you approve. In the hospital context, what I have seen most often is that underneath anger and mistrust is anxiety and fear, just as you concluded. The antidote to those feelings, as you demonstrated so well, are patience, respect,

attention, and if possible time. Many of the patients/family members in these situations will alter their demeanor (some of course will not) and this will make care of the patient easier for the team and more rewarding for patient/family. I respect that you did not allow the wife's behavior to push you away, but rather drew closer so you could improve your understanding of the situation.

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--, I commend you for your sensitivity to several aspects of this sad case. First, you wondered about the soundness of switching from a recovery plan (nursing home) to a comfort care plan (hospice). Second, you felt constrained because of your lowly status in the medical hierarchy to raise the question with the attending. Third, and most significantly, you were troubled by the fact that the patient, despite having cognitive capacity, was not able to be included in this existential decision.

Each of these is a significant issue. Although from your description of the patient's state, hospice care might have been a very appropriate recommendation, it is still important to consider issues of ageism in treatment decisions about elderly patients. And one important way of minimizing ageism is to ensure the patients themselves are included in the decision-making process!

The culture of medicine is hierarchical, and those at the bottom (i.e., MS3s) are often not allowed a voice. This is truly unfortunate. Sometimes the voice from the bottom has an important point to make, and sees something more experienced eyes have missed. Even when the more experienced voice is ultimately the one to follow, question and discussion facilitates the learning process for the student, while encouraging the attending to question her or his own thinking.

Finally, the tragedy here (if I am understanding correctly) is that because of the patient's deaf/muteness and illiteracy (which I assume extended to no knowledge of sign), it was literally impossible to communicate with him meaningfully about decisions affecting his life. To me, this seems to be not a human flaw or even a systems failure, but one of the unavoidable limitations of our human existence. If that is the case, then as you say eloquently, you must indeed accept that you did the best you could under very difficult circumstances.

That said, with what you knew about the patient's desires (go home), I still wonder whether home hospice might have been feasible. If not, because of

circumstances/insurance etc., then it is all about taking a breath and doing your best to make the patient feel safe and ease the transition.

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Dear --, I always learn something from your thoughtful reflections and essays. Here, you educated me about the distressing health future awaiting previously incarcerated patients. Horrifying, but as you outline, given the almost total lack of social resources and supports, not really surprising.

There are two points I'd like to underscore: 1) The burden of solving these complex problems should not fall primarily on the shoulders of committed and caring individual physicians. This is a systemic issue that needs to be addressed at state and national levels (although the likelihood of this happening any time soon seems low). 2) It's important to celebrate the small victories, such as your getting your patient two months worth of medication. This may not be enough, but that is what you could do and you did it (where others might not). In the face of the enormity of need and suffering, I believe the capacity to do what you can and not beat yourself up for what is beyond your control is key to not burning-out and continuing each day to be grateful for the opportunity to be present for others.

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--, it seems to me you handled this potentially challenging situation really well. In my read, neither person was wrong. The evening meeting sounds as though it could have been and interesting learning experience - but the timing was terrible for overstretched med students trying to prepare for the Shelf exam, which could have significant consequences for them. Especially for people who are conflict avoidant (such as myself!), learning how to speak up (not being too passive) respectfully (not being excessively aggressive, as we mobilize our energies to do something we hate :-)) is a really important skill. Remembering that hearing and valuing (without necessarily conceding to) the other's perspective, then stating one's own position clearly but without personal attack, seeking common ground (in this case, the success of the students on the rotation), can make the difference between conflict and disagreement. I was very impressed that you went back the next day and talked out the situation with the resident. People will disagree and it's important to try to understand each other and find ways of continuing to successfully work together, which is exactly what you did. Well done!

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--, as I said in my comments, the fact that you were able to elicit this complex and painful history, that you were able to get your patient to open up through an interpreter, and that you were able to recognize the true source of the patient's suffering. You are so right that many physicians avoid social issues because they do not tend to be straightforward. Still, by overlooking them, you can severely limit the effectiveness of your medical treatment because of nonadherence, lack of trust, misunderstanding etc. How easy - and how pointless - it would have been to give this woman medication for back pain. You have your central principle well in hand - "[In this encounter, how can i best serve my patients?"]. If this is your north star, your starting point, you will always be on track. You likely are not going to be able to solve all their problems, but you and the patient together will be moving in the right direction.

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--, this sounds like a very sad and painful situation. There is a lot of distress and confusion over end of life conversations. Doctors often say "I've told the t patient/family" while patient/family process ignorance of the dire prognosis. No one is lying, but because the physician has not been clear (or has been clear in such a coldhearted manner that the family rejects the information) and because the family generally does not want to hear what is being said, the discussion can easily go sideways. Like any important communication, it is important that the physician know that the information has been received. It is also extremely important for the physician to be patient, empathic, and compassionate, never forgetting that they are giving people the worst news of their lives.

I hope since this event that you have seen other examples of EoL discussions that have exemplified qualities of directness, honesty, and caring. They can occur, and when they do, they significantly alleviate the suffering of patient and family. I commend your resolve to bring this kind of compassionate truth-telling into your future patient interactions.

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Dear --, I appreciated your generosity toward this resident and your resistance to reflexively judging her. I also agree that the physician's emotions should not be front

and center in the exam room, delivery room, OR etc. How we get our emotions to subside and take their proper place in the encounter is an interesting one. Awareness is always a good place to start, followed by an intention not to let a problematic emotion adversely interfere with patient care. This involves admitting to emotions that we might prefer to ignore; then it involves attending to them (through breath, through commitment to address them later, through thinking about the patient from a different, more compassionate perspective) so that they are not intrusive. As you well know, compartmentalizing is not the same as pretending the emotions are not there; and they deserve attention, but not in the patient encounter. I think one of the hardest challenges is returning to a negative feeling, and trying to honestly figure out where that feeling came from - was I just hungry? Exhausted? Was I afraid and blaming the patient for putting me in a scary situation? Did I have judgment toward the patient's choices? Reflecting on such questions is where the learning occurs about how to truly achieve good emotional self-regulation.

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Dear --, what an insightful and humble essay. I was so glad to read of the humble guidance your attending provided. Your conclusion is correct - there is no one right way to conduct an interview. But listening to the patient, following their lead, and respecting their sensitivities is a good beginning. as is your openness to acknowledging a misstep. I admired that you stayed present with your patient and took a different approach to remedy the shaky start and establish connection and rapport. Knowing that there is no infallible guarantee of "success" especially in difficult encounters paradoxically creates a kind of freedom. It is all about making a sincere effort to create the best connection possible under the circumstances and use it to advance the patient's wellbeing. Patients I have learned, and people in general, will forgive a lot :-)

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--, you are so lucky to have had the privilege of witnessing this happy resolution of this patient's medical and social difficulties. One coping strategy to consider in clinical medicine, where you often do not have the opportunity to see how the story turns out, is to imagine that things might have turned out well. Often as physicians, you plant seeds, but don't get to see them bloom. Of course, some seeds shrivel and die, but many do spring to life. Holding out that possibility can give you hope to continue your sometimes challenging task of patient care.

I also admired that, despite the unlikability of this patient, you worked hard to see things from her perspective, and realized that beneath her difficult interactions lay a lot of fear, lack of support, poor resources, and some personal instability. Understanding the complexities of the patients you care for, even when you cannot always remedy them, gives you a more clear-eyed view of those under your care and sometimes more insight into how to treat them.

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--, I applaud your commitment to finding ways not to be demeaned by patients while at the same time figuring out how to get that patient the care they deserve as a suffering human being, no matter how obnoxious, inappropriate, or even racist they are. In this case, the way your patient spoke to you seemed highly improper and unacceptable. As you realized, it made it difficult for you to care for the patient in the way you wanted. At this point, it is important to address the situation (and as I noted in my comment, I think it is the responsibility of team members to set limits on such behavior for each other). Just as you are not expected to accept physical abuse from a patient, I do not think you should have to accept sexual and racial innuendos.

Speaking up and setting limits on another person can be difficult; and speaking from personal experience, I know that initially I tended to be pretty aggressive when I finally managed to speak out because it was so hard for me. I've learned it is possible to be kind, compassionate, and VERY STRONG in your boundaries. As you say, it is all about practice. Neuroplasticity has shown us that literally, what we practice grows stronger (changing our brains).

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--, there is no question that you handled this in a respectful, professional manner. And you are absolutely correct that standing up for yourself – and for what you know to be right or correct as the case may be – is a critical lesson. The fact that there is a power differential does complicate the situation, but it does not fundamentally alter what should be done.

I'm glad to hear you've reflected on this situation because of course, as you know, it will arise again and again. To build on your thinking, I would only suggest that *what* you should do is clear; so what deserves some thought is the *how.* First, it's helpful to

as yourself, what is my goal? True, part of your goal is standing up for yourself; but perhaps even more important is helping your resident see that she has incorrect information and that better information is available. Since you want to educate your resident (who is your superior), you want to think about how she will feel when you point out she is wrong and you are right. At a guess, I'd say she'll probably feel awkward, embarrassed, maybe even shamed. So now you need to figure out what approach will reduce her shame, so that she can most easily absorb the correct content you are offering her. In other words, you want to make her feel safe; and you want to be a team with her. Rather than fighting vs. fleeing, yo u are looking for a strategy that emphasizes cooperation and collaboration. For example, you might talk to her privately, where there is less chance of public humiliation. You might say, "Thanks so much for helping ensure that I know these guidelines. It's great this is coming up now because I had to memorize them as part of my FM rotation. I think I'm recalling them correctly, but why don't I double check and I can send you what I used." You may be surprised how often, STILL, in clinical settings, physicians follow "what we've always done" vs. EBM, so as you realize it is vitally important to know how to address these issues tactfully, respectfully, but with great clarity.

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--, I think there is an important lesson here. (My next comments assume you are going into optho). Vision is SO IMPORTANT to people, and that is one of the things that makes opthalmology rewarding, because by restoring/improving/saving sight you can make people very happy. However, it also means there's a lot at stake whenever eyes are involved, so your patients may be more anxious and vigilant, and need more reassurance as well as nuanced understanding of what they can expect from treatment.

I agree entirely that clarifying expectations in advance is the ideal way to go. Of course, sometimes this is not successful - the patient is still disappointed, and you're saying "but I explained all this to you before the surgery!" Naturally, people want to go back to their pre-illness/condition state, and it's scary to think that they might not. Being patient with their resistance, giving them realistic hope while making them aware of potential downsides, and then empathizing nondefensively with their disappointment will go a long way toward helping ease their distress.

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--, this is a wonderful story of your growth as a student physician. It is of course completely understandable that as a naive starting 3rd year, you might not have a framework for assessing the extent of a patient's suffering; and might question their requests for medication as drug-seeking. The important thing here is that you had a trustworthy guide who could provide a more experienced context; and you could interrogate your own assumptions and attitudes. Better still, once more informed, you were able to alter your approach toward a patient you had misjudged; and the result was an important connection that could improve the care you rendered. I have great respect for how much you developed as a result of this single encounter. Every patient has a lesson to impart, and this was one you learned very well.

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--, you put your finger on a big problem when you identified differing expectations of patient and physician about what can happen in the ED. Especially for patients who may not be familiar with the healthcare system, I think your speculation regarding expectations is often true: I need help from a doctor; these people are doctors, and they're not helping me. Depending on the patient's insurance and immigration status, I would also worry that he might not have the resources to follow-up with a specialist. And of course, as you say, language differences complicate everything.

It sounded as though in this case the team handled the situation very well. It would have been understandable to feel frustration, and I'm sure people did. However, what was owed to the patient was a clear explanation of what the ED visit could offer and what it could not solve; a patient and respectful discussion of what the visit did show (no life-threatening situation); and a realistic plan to help the patient find the care he needs. By taking the time to deliver this care, the patient stood a better chance of actually being helped.

When dysfunctional patterns emerge, it is easy to blame the other person. Why does this guy keep coming back to the ED? We've told him we can't help him and he needs a specialist. A better insight is to say, as your team did, what we've been doing isn't working; let's try a different approach (better communication, patience, addressing expectations etc.) As you noted so empathically, the patient just sees a doctor who doesn't appear to be helping. The "help" that the ED can provide in this situation is breaking the cycle and making a sincere effort to create a different outcome.

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--, how nice this story had a happy ending. It seemed obvious that a family conference was needed, but this required a little out-of-the-box thinking. Mom and dad dislike and avoid each other, never visit together, so how could we ask them to a joint meeting? In this case, it was the parents' themselves who came up with the idea, and this might have been the ideal situation: Rather than have togetherness forced on them by the medical team, they reached the conclusion independently that this is how they could best care for their son.

Of course, given the seriousness of the kid's medical condition, if the parents did not initiate, then the team should. Even here, it is important to keep in mind family dynamics and present the suggestion in such a way that fits with their view of themselves: "We've noticed that although the two of you don't always get along, you are absolutely both devoted to your kid. With that in mind, we think it will be so helpful to dealing with his illness if you could sit down with the team together..." This approach respects that you are asking a lot of them and frames it as a conscientious prioritizing of their child's wellbeing over their own disagreements.

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Dear --, you told a beautiful story, with a wonderful narrative arc. First your parents cried and wailed, and you argued back. Then you realized the uselessness of repeating the same dysfunctional pattern over and over, and did something different - and irresistible: you started telling stories; and just like the king in 1001 Nights, your parents were entranced and wanted to hear more. Soon they came to love the stories, and after a while, they came to see you loved the work that created those stories, and then because they already loved you, their story of sorrow and shame changed to one of pride and support. All from the power of storytelling :-)

On the theme of stigma toward psychiatrists, which is widespread both within the medical community and the larger society, I note a KevinMd blog on the topic in my comments as well as the attached article. Much work to be done here!

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Dear --, thank you for sharing this difficult experience. I'm not sure I interpreted it correctly, but I thought that in addition to the patient just being rude, antagonistic, and demanding, it was possible based on his initial questions, that there was also an

element of racism or at least implicit bias driving the patient's wariness and lack of honesty.

I think you are absolutely right that, in most cases, patients' bad behavior is less about you (or some other care provider) per se, and more about their own fear, anxiety, uncertainty, distress etc. But sometimes, issues of race/ethnicity, gender, sexual orientation, religion, disability etc. act as triggers through which the patient manifests their underlying concerns. In such cases, my view is that the physician can maintain a therapeutic relationship with the patient (if the patient is willing), but also has the right to set some limits on abusive or demeaning verbal behavior. This is often easier to do when you are an observer (as in the case of you and your resident) than when you are the target. In other words, it is easier to support and champion another, whereas the tendency of many health professionals is to "ignore" these sorts of assaults. Yet we are learning that the wounds to sense of self that result from such attacks are greater than we initially realized.

It is always an option to make explicit that which lurks beneath the surface. "You seem angry with me, and mistrustful. This makes it hard for me to take care of you as I'd like. Help me understand what's going on." Such a statement forces the patient to take responsibility for their behavior, while potentially opening new, and more fruitful, paths of communication.

--, these are tough issues to address, especially in written form. I have not walked in your shoes, and cannot understand fully how you perceived this situation (in fact, I probably understand very little). In the end, it is up to you to respond to such interactions in ways you feel will best support your patient's wellbeing - and your own.

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This situation became a lot less difficult simply because you listened, which conveyed both respect and caring to this distraught mom. You are absolutely right that, as a resident, you will not have "hours and hours" to sit with a patient and family member. Yet, in my view, being present is only partly a function of time (of course, it helps to have more rather than less time). When you are fully focused on and attentive to patient/family, there is a different atmosphere in the room and time, weirdly enough, becomes elastic. People feel seen and heard, even when the actual time elapsed is fairly minimal. I'm not suggesting that knowing how to be present solves the time

crunches that face all physicians. Of course it matters how much time you have with a patient, but it also matters how you use that time. Even a couple of minutes where you just listen can establish connection and build trust.

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Dear --, this was a disappointing situation from the perspective of your not being permitted in the OR as an advocate for your patient ; and an unprofessional, even hostile work environment because of the nurse yelling and acting in an arbitrary manner. In contrast to your rather harsh judgment of yourself, I did see you standing up to the nurse twice. You "interrupted" and you attempted to find a workable solution. How far to take the exchange is a difficult question.

One issue I think has to do with the particular circumstances. In an extreme condition (where, for example, you had sworn to X for whatever reason that you would be there to remind the surgeon of certain specific wishes she had directly expressed), then even as a lowly medical student you might have tried to go above the nurse to the attending herself. However, as you know, this might have created a lot of animosity toward you (defying the circulating nurse), unfair as that would have been. So you have to way the benefit to the patient vs. the cost to you as a medical student. In the hypothetical case I posited, it might have been worth it. In this case, where you were only "generically" going to be there for X, you likely chose the wiser course of action.

Another issue has to do with the nurse's behavior toward you, which sounds at best inappropriate and at worst emotionally abusive. I tend to feel that, if possible, such behavior should not go unremarked. Again, you are weighing benefits to future students (and perhaps the team as a whole or nursing students over whom she has power) vs. cost to yourself. You might decide it simply isn't worth the hassle and discomfort and do nothing. You could also write up the nurse anonymously. Finally, and my preferred option, is to seek out that nurse at a later date, and share politely and professionally (as she did not) why it was so important for you to be in that OR and how the interaction affected you. When you are only on a rotation for a short period of time, this might seem like excessive effort for little reward; but in your long-term career, there will be many instances of interpersonal tension or conflict where no one is moving anywhere, and it will have to be resolved for the good of patients and the team.

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--, you helped me realize that it is easier for me to be compassionate toward those who may share more closely my own philosophy and view of life than toward those who represent everything I have stood against. Yet you are absolutely right that all deserve care and understanding; all deserve to have their stories heard.

That said, my opinion is that while physicians must treat all patients to the best of their ability, they do not have to accept racial slurs or other insults directed at staff, colleagues, or even themselves. Limits can be set, and targeted staff supported, and this can be done in ways that are professional, calm, and yes compassionate.

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--, thank you for this humble and insightful essay. In reading it, I was amazed at your courage and perseverance. This patient would have been very easy to write off. It seemed pretty obvious who she was - angry, violent, uncommunicative etc. Yet you were willing to entertain the possibility that there was something more there - and to approach her with hopefulness and compassion to give her a chance to express this other side. By learning your patient's story, you discovered the very difficult, overwhelming circumstances of her life, and this enabled you to avoid simple judgments and assumptions about her.

I love that you want to learn more about your patients' stories and see how their lives unfold. Sometimes you have to believe in a patient even when she has stopped believing in herself. This doesn't mean being naive or seeing what isn't there. But it does mean having an open mind about people's capacity to grow and change. This is true for doctors and it is also true for their patients.

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So --, if I were interviewing you, and you were sleep deprived and accidentally shared one of these less-than-optimal outcomes, this is what I would ask you: What would you do? In the face of societal injustices and colleagues' inappropriate ordering practices, how can you respond?

In my mind, we can always respond on two levels: 1) Instrumental - fix the problem (work toward greater health equity on a political level, get the bottom of what drives ordering practices in your hospital) and 2) Attitudinal - always be compassionate and

caring toward the person in front of you (i.e., your patient), even when you can't help them the way you'd like. Have the courage to witness their suffering and say, "You did nothing wrong. The system I'm part of has failed you." This is very hard to do, but it avoids blaming the patient and helps them to feel that you see their suffering.

The third scenario to my mind is a little different as it raises an ethical question about quality of life and what sort of life is worth living. It sounded as though the ICU team wanted to institute palliative care without thoughtfully considering whether this woman was ready to die. Maybe a "happily demented" life is not a bad life, we just don't know. In the face of this uncertainty, in the absence of increased suffering as the result of her multiple hospitalizations, and in the face of the son's desire to keep his mom alive, I'd say this move toward palliation might have been premature and rooted in certain assumptions about what qualifies as meaningful life. If I'd been your interviewer, nothing would have seemed more worthwhile than to discuss this question with you!

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--, I appreciate your conclusion that you will be more conscientious and patient with patients and family members struggling to come to terms with a difficult diagnosis. I do think perhaps you are minimizing how well you handled what sounds like a heartbreaking situation. You and your resident approached the patient with kindness, which it seems she appreciated. You listened to the sister's raging grief (and you correctly identified her anger as primarily grief). This may not seem like much, but simply being present, not "abandoning" the sister in her pain, is truly a great gift. I think this is why she was so repentant. She realized you both had stayed the course, and she realized this was a precious thing.

See my comment about tissues. Most times they are appreciated, but once in a while they can backfire :-). As you conclude insightfully, there are no surefire algorithms when it comes to grief.

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