AoD 2018-2019 CLINICAL OBSERVATION

--, I appreciated your acute powers of observation regarding Dr. X. I think that ability to stay calm and fully present in stressful situations is a great quality in a physician. Note as well that calmness is not the same as detachment. Dr. X in fact went out of his way to connect on a human level with the patient, when he could have just run through the PE as quickly as possible. To me this example is a perfect illustration of combining steadiness (the capacity to contain the chaos and sense of overwhelm that often emerge in the presence of illness) and tenderness (caring about those in the midst of that chaos). I'm glad you found such a great role model, and doubly glad that you intend to emulate these qualities in your own patient care.

As always, a perceptive and insightful essay, --. In reading it, I felt you as very present in this encounter, very attuned to all that Dr. X was doing to create an effective and successful interaction with a challenging patient.

I also appreciated that you observed the contrast between Dr. X and the rest of the team, who dealt with the challenges by moaning and groaning and labeling patient and mom and difficult and demanding. This reaction is quite understandable, but not justifiable. When possible, being present with patient and parent, being respectful of their viewpoint, being kind and caring will do much more to advance the patient's treatment than eye-rolling, which puts patient and parent in opposition to the team. In that regard, this encounter also teaches us not to succumb to group pressures - just because everyone else on the team is exasperated and annoyed does not mean that you need to adopt this attitude. Indeed, I am sure you will not; and instead will remember Dr. X as an inspiration even in difficult circumstances.

Dear --, I loved the way you wrote the first paragraph of this essay. It is truly beautiful, and the Gyn-Onc Fellow moves through the sentences like a kind of goddess - serene, compassionate, graceful, patient, humble, honest, strong. No wonder you admired her interaction with this patient and all those who followed.

The second paragraph does a wonderful job of summarizing everything that made an extremely difficult conversation the best it could possibly be. The kneeling to eye level, introductions, the pausing for silence and avoidance of rushing, the recognition

of the time delay in absorbing such dreadful information, her willingness to return and do it all over again - all epitomize the art of medicine in action. That you recognize this so deeply assures me you will follow in her footsteps - and make them your own.

--, even in psych you want to believe your patients, but sometimes you aren't getting the full story. In this case, the tech's prior knowledge of the patient and keen observations helped fill out the picture. Apparently the patient was trying to avoid an arrest warrant (an understandable motivation from his point of view), but undoubtedly he also remains a deeply troubled individual who needs ongoing psychiatric help. One hopes against hope that, if convicted, he will continue to receive that in prison.

Dear --, working with Dr. X is a real opportunity to learn important things about superb doctoring. You did a great job of observing him carefully and figuring out some of the attitudes (patience) and behaviors (exploring patients' feelings, acknowledging unasked questions) that make him so good at what he does. I love that you have already incorporated his invitation to patients to "tell me your story." This is pretty rare, but it really makes a difference to patients who feel seen and heard by the physician and still in possession of their own story, which otherwise can seem to disappear from their control.

--, I completely agree that when a physician has a "hunch" about a patient, she or he should try to pursue it, not simply let it go in the face of patient denial. How you do this matters. You can convey that you disbelieve the patient, that you are right and they are wrong. This rarely goes well. On the other hand, you can try to create a safe environment so that they are able to share aspects of their lives that seem shameful or embarrassing to them. You can do this by normalizing ("Many people find it hard to talk about mental health issues") or by returning to the topic from a different angle ("You know, I asked you about a psychiatric history earlier. I might not have been clear and you might have misunderstood me. I was interested in whether you'd ever experienced common problems that many people have, like depression or anxiety"). This way you persist, while respecting the patient's dignity.

--, I thought you gave a very honest and thoughtful assessment of what you find frustrating about outpatient, and why surgery and inpatient medicine in general are appealing. Know thyself, and you'll be much the happier for it :-)

Your point about all the invisible work physicians do is very well-taken. You are absolutely right that there is a disconnect between what the physician does and what the patient sees the physician doing. As I comment, sometimes, especially when the patient seems to feel they are not getting enough attention, it is helpful to explain (nondefensively) just how hard the doctor is working on their behalf through the efforts of all team members.

Hi --, it's clear you have been paying careful attention to both positive and negative role models throughout your training. That's great, there is so much to learn - and not just about medicine - if you keep your eyes open.

The points you make in this essay are well-taken. No one should hear they are going to die from an iPad. You also issue an important warning about being honest about one's language limitations. There is so much pressure to be efficient and productive, it's easy to rationalize that you have "enough" Spanish to get through the encounter. Sometimes this is okay - routine ob check, no problems - but sometimes it gest the physician in real trouble - only it is the patient who pays the real price, as you note in your essay.

The final point to consider is that, even when there are no language or cultural barriers, it is hard to give this news to a patient in the way the patient can really hear it. Being both clear and compassionate is essential to supporting your patient while helping them to understand the truth of their situation.

Hi --, glad you had this positive experience, and especially glad you had a chance to process it with the resident. As you saw, you and the resident had very similar feelings. Dr. X proved to be an excellent role model in managing these emotions so that they did not drive the interaction; eliciting his patient's agenda; and forming an

alliance so that patient and doctor could work together to achieve shared goals. You extracted exactly the right lesson from this difficult encounter - look to the relationship first; the medicine will then follow much more easily.

You chose a great role model, --. Role models come in all shapes and sizes - some are warm and fuzzy, some are gruff, busy and tired. The important constant is their dedication to the humanity of their patients. In this case, X the resident saw the gap between the human needs of this young man and the inundation of procedures, jargon, and teams that overwhelmed him. Through X's faithful attention and caring explanations, the patient felt included in what was happening to him and better able to face it.

I also liked your point about how X behaved when there was no one to see and no external rewards to achieve. Sometimes I worry that all the testing of medical students with OSCEs makes every patient encounter seem like a performance with an audience and hopefully applause. Hopefully, these external criteria become internalized so that physicians treat their patients with care and respect not to earn a grade but because such attitudes and behaviors contribute to the patient's wellbeing and bring the physician a sense of satisfaction and even at times joy.

Hi --, now I've had a chance to actually read your essay, I enjoyed it - and the humanism it expressed - very much. (Incidentally, I'm sure you've heard about the still-in-trials breakthrough in the treatment of sickle cell that may actually result in cure!). What I liked so much in your perspective was your acknowledgment that patients, particularly patients with chronic diseases, know a great deal about their individual bodies. As you suggest, by making the patient a valued part of the team, both team and patient can benefit. The opposite response (doctor knows best) is patronizing and short-sighted. Ultimately, it is the patient and the taxpayer who suffers.

I really appreciated your metaphor - shoulder to shoulder rather than chest to chest (which I assume implies a more superior/inferior position). If this is your guiding partner, your future patients will be very grateful - and helpful to your efforts to care for them!

--, I'm glad to hear you had this positive experience. Too often, as you know, patients'/families' cultural expectations and beliefs are trampled on intentionally or not in the healthcare system. The example you cite, as you point out, is a superb manifestation of patient-centered medicine. As you noted, here the parents were included in the decision-making process, and the team worked diligently to honor their requests while ensuring the safety of the patient.

To me, this case epitomizes the value of humility in medicine - having the capacity to consider that, in some respects, parents may have expertise about their child that physicians do not. The ideal is to work together to integrate all forms of knowledge and understanding to arrive at a shared solution - which is exactly what happened here.

Finally, as I'm sure you realize, parents do not always have the confidence to engage with physicians when there is a difference of opinion. In these circumstances, it is incumbent on the physician to take the initiative, and make sure parents understand that their ideas, concerns, fears, disagreements are welcome in the conversation and will be heard and respected.

Of course, as you intimate X, what is difficult about this case (other than EVERY ASPECT OF IT!) is that the patient's wishes were unclear. My understanding is that physicians may legally withhold treatment requested by a patient if an ethics committee deems it futile (and similarly for family wishes). However, with a clear statement from the patient to keep her alive, despite pain and suffering, so she could continue to spend a few moments of lucidity with her family, I would be inclined to respect that. I suspect that this state of affairs would not have endured very long.

Since that was not the case, I would have wanted to understand better what it was about quantity of life that mattered so much to the family. Was it faith-based? Was it unfinished business? Was it anger at the hospital whose intervention had only made matters worse? Understanding what made the family so entrenched may hold the key toward preparing them to let go of their wife and mom.

Most medical students say they learn much more from simply observing outstanding role models (and also from anti-role models) than from classroom lectures, and I agree. You have amazing role models all around you, not only in terms of their impressive medical knowledge, but also their interpersonal sensitivities and skill. The key is to pay attention to all dimensions of the interaction, which initially can be overwhelming. Now as a 4th year student is an excellent time to really focus in on the subtleties that distinguish competent physicians from truly exceptional ones.

You put your finger on an essential ingredient - that of balance between professional requirements (explaining the diagnosis, treatment options, implications for future childbearing) and human requirements (compassionately receiving and acknowledging the patient's fears and distress). It seems like you had an outstanding role model who embodied this balance. Just keep her in mind as you move forward, and she will serve as a trustworthy guide.

--, your attending made a worthwhile point, which is WHO WAS THIS WOMAN?! Of course it is always important to be clear on which family members receive what level of information. So a cautionary note was appropriate. That being said, we have to put that note in the context of a history of excluding patients and families from discussions about them. Bringing patients and families on-board as shared decision-makers is a healthy, long overdue trend. We just must make sure we use it wisely.

Dear --, you've chosen well in modeling yourself after Dr. X. Her approach to her patients gives the lie to the belief that being emotionally invested in your patients leads to burn-out. Rather, at least for Dr. X, the opposite seems to be the case. She cares about each and every patient; and even the siblings of every patient. She is not fazed by patients who are late or patients who do not understand her recommendations. She makes each patient and parent feel cared for and significant.

I think one lesson we can extract from Dr. X is that connection with one's patients can be uplifting and revitalizing. As that one mother's remark indicates, caring is a two-way street. It is clear that gratitude, admiration, and appreciation flow from her

patients and their parents toward Dr. X. In this way, her passion to do good is renewed daily.

Going that extra mile is hard, of course, but it brings many rewards as well. In fact, unless taken to unhealthy extremes, it results in better cared-for patients and happier doctors who know at the end of the day they have done their best for their patients.

--, your pithy essay fascinated me. I have heard of families becoming (understandably) upset, angry, distressed in the ICU setting; but the phenomenon you described is one I was not aware of. I don't understand it entirely, but I'm wondering if it has something to do with the family members "mirroring" the detachment of the physician toward them by displaying a similar lack of emotion toward their loved one - maybe the doctor has disconnected, we should too, this is how people behave in this already cold and intimidating setting?

I think the conclusion you draw is just right. By acknowledging the humanity of the family, you help them remain in relationship with their loved one (who may seem very unlike the person they have known and loved). It's just really intriguing that the physician and team, at least sometimes, seem to set the emotional tone. If this is often the case, then it behooves the physician to think carefully about what messages they're communicating.

--, I really liked the way your essay both identified the fundamental disconnect between many patients who seek nonemergent care in the ED; and physicians who are trying to identify those "actively dying" patients who need immediate attention; yet found many examples of residents/attendings who understood the patient perspective, treated them with dignity, and tried to provide both comfort and treatment.

Extrapolating to your own future practice, in every specialty there are many situations that the patient perceives as serious, but the physician knows are routine. If the physician displays impatience, exasperation, and suggests the patient is wasting his/her time, the patient is humiliated and alienated. If, on the other hand, the physician is able to recognize the patient's fear/anxiety and address the concerns

respectfully, the patient will feel validated and affirmed. Which patient would you want to care for?! Just keep taking those breaths :-)

--, you make an excellent point about how to handle a situation when you are the latest doctor in a long string of doctors. I thought you parsed the issue very well - you can highlight your specific expertise as distinct from many other specialists in the same area, while not denigrating their skill. I agree it is a fine line. As you insightfully observe, the goal is to instill confidence in your ability to help your patient, not to undermine their view of previous physicians, which in the end tends to lead to greater skepticism about medicine as a whole, and thus circles back to bite you!

Thanks -- for sharing this example of an excellent role model. In most cases, these outstanding physicians are not doing something extraordinary - communicating patiently, listening carefully, being fully present - but the effects on the patient can be tremendously positive. You did a great job of analyzing why Dr. X was so effective with his patients. Just as you would carefully observe a superlative surgical technique, by paying close attention to a role model's interpersonal interactions, we can learn the elements of what makes her or him so great, and then figure out how to incorporate them into our own interactions.

--, Dr. X is such a skillful and compassionate physician, you are lucky to have him as a role model. Thank you for your attentive observations, which I hope helped you to identify exactly WHAT makes Dr. X so great. His care with small details (such as wiping the gel); his patience and willingness to be present with patients; his sensitive personal disclosures; and his reminder to the family to think about the patient's wishes, not their own are all compelling examples of a humane, caring, and respectful patient-doctor interaction. The art of medicine is all about identifying inspiring role models, then knowing how to translate their abilities into your own style.

--, thank you for these excellent observations about Dr. X. You summarize the essence of what makes him such an outstanding doctor - his ability to be a person as well as a physician. This is evident in his willingness to share on a personal level, to experience sadness at a patient's suffering, and to follow-up when one of his patients is hospitalized. All of this says to the patient, I am your doctor with great knowledge and expertise which I will use on your behalf. I am also a human being, just like you, and we are all just walking each other home. This attitude is summed up in your word humility.

--, what an incredible learning experience. I am so very glad you had the opportunity to witness such a skillful goals of care conversation. You identified exactly what made it so impressive - this balance of calm, honest disclosure combined with real caring and concern. I also loved the way the fellow stopped the business-as-usual approach of the resident (as you say, perfectly reasonable from one perspective - just pursuing the agreed-upon course of action) and shifted the discourse entirely to the real issue - the patient is dying, how does she want to spend the rest of her life. That the fellow took this step with a patient she had never seen before to me is evidence of a truly patient-centered approach. She could have chosen the easy way - avoiding the topic entirely, as everyone else had - but instead she saw what this patient needed, and had the courage to initiate moving care in an entirely different and much more relevant direction. Good for this fellow, and good for you for taking it so much to heart. I am confident you too will be able to demonstrate this combination of steadiness and tenderness with your future patients.

As I'm sure you've seen --, often when the physician is not sensitive to the needs of the family in these terribly distressing moments, his or her sense of urgency and eagerness to "get an answer" only makes the family feel pushed into a decision and uncared for. Several times I have seen these situations end in acrimony and bitterness, with a decision taking even longer because the family no longer trusts the medical team.

It is so refreshing to read about a physician who is willing to "slow things down" so that the family has the time they need to process devastating information. From what I've seen, when family members are not busy warding off demanding doctors, they

can concentrate on their grief, resolve any differences that exist, and reach a decision. Respecting families' processing of the loss of a loved one is the least we can do to support them through this heartbreaking time.

--, I respect and share your admiration for this resident. Sometimes in medicine we try to make things simpler than they really are. End of life can be simple, but often it Is not, complicated as in this case by cultural, familial, and system factors. Futile treatment is an important concept, but it should never be used to sweep complexity under the rug. I admire that the resident in this case advocated for the family, even though she did not share their beliefs.

Also, although I respect the resident's commitment to the family and all the time and effort she obviously invested in talking with them, it is really challenging to have end of life conversations by phone. It may have been unavoidable, but it helps to read nonverbal language in these situations, and to look at people face to face in discussing the impending death of a beloved matriarch.

It is always a pleasure for me to learn about a colleague who is doing such good work. I appreciated the dedication and humility you described so well.

Your point about language fluency is very well taken. Of course, in my view, it is incumbent upon the physician to try to learn as much as possible about the community and patients among whom she practices. But sometimes learning a language later in life can be a challenge, and this should not necessarily deter otherwise committed physicians. I agree with your observations that other factors may compensate for lack of fluency - including effort to use the language skills one has; an effort to grasp aspects of the patient's culture that might be relevant to the treatment of their diseases; an eagerness to establish a human, as well as a medical, connection (sometimes through humor). All of these are ways of letting the patient know you are committed to their care, you value and respect them as a person. It sounds as though you've found an outstanding role model on which to base your future patient interactions.

--, I was shocked to learn of an attending interrogating a patient regarding immigration status. This is an entirely inappropriate - and likely terrifying or insulting - question for a patient. Despite the fact that, indeed the patient's care will not be affected and the patient will not be turned over to any governmental body, it would destroy trust and reverberate in the treatment of the patient in many negative ways.

I was in awe of your initial refusal to translate the attending's question (of course, he did not speak Spanish), and of your persistence in exploring the rationale for the question in the first place. You were very brave, and I admire that. I also feel that, if you are willing to risk the annoyance of the attending, it is absolutely the right action to take. If you are silent, that attending will never have an opportunity to reconsider his behavior. It doesn't sound as though he realized the stereotyping and bias that characterized his question, but without your challenging him, there would have been no possibility at all of his learning anything from this interaction. All we can do is hope that, late at night, the polite but pointed queries of a young medical student stuck in his mind; and perhaps he at least considered the possibility that he had been wrong.

--, you eloquently realized exactly why this physician's behavior toward these severely neurologically disabled kidoes was so important. He still sees them as human beings - which is what they are. This sends a vital message to the parents - perhaps one of hope, but I think more importantly, that their child, as he or she is, is still deserving of respect and care. Maybe the chlld him or herself at some level senses this. Who knows? And finally, it reminds the physician himself that all living beings are deserving of his attention, presence, and concern.

You shared an excellent insight that the knowledge physicians possess can make them dismissive of the impact of the disease on patients' and families' lives.
Perhaps the best antidote to the feeling of power and superiority that comes from expert knowledge is humility; ie., remembering that, although physicians do understand many things better than laypersons, there are still mysteries that elude even medicine. These include intangibles such as hope, love, dedication - qualities that we often find in parents of kids with disabilities. I think that by recognizing the essential dignity of his patients, the neurologist also demonstrated a humility that honored all that he does not understand in what binds such families together.

Wow, this encounter sounds like the prototype for a negative role model. I respect that you tried to consider what might make the attending behave in such an unkind, insensitive manner (burn-out, desensitization to suffering, time and efficiency-driven), but as we discussed today, in fact these behaviors are unprofessional and violate the social contract that exists between patients and physicians. Nevertheless, as you realize, we can learn as much from negative role models as from positive ones.

It is especially worthwhile to ponder how that physician lost the empathy, sensitivity, and patient/family-centeredness that you display. Possibly he was always a jerk, but more likely the stresses and strains of the profession and his own lack of positive coping have taken a toll.

I'm always struck when compassionate, kind medical students transform into cynical, disillusioned residents. It is not their fault; rather it is the systemic flaws that prioritize efficiency and productivity above all other values that lead to such attitudes. Nevertheless, until such time as we can change the culture of medicine, physicians must do all they can to remain open-hearted, tender, and caring.

One of the ways for you to do so is to remember this son's struggle to understand the horrors overtaking his mother. When you think of him, your heart will soften, and then you can carry that heart into the room of your next patient.

Excellent essay, --. You did a terrific job of identifying the elements of this interaction that made a rare and challenging diagnosis a little less scary: the attending provided information that was relevant to the patient, she formulated a plan of action, and identified resources and support. As you observed, she effectively partnered with the patient and family. What she did NOT do was trivialize or dismiss the patient's anxiety. She recognized that this was a fearful development in this young man's life, and did everything she could to make it more understandable and more manageable.

I see you applying all the skills you observed in this attending to your own approach to patients. The art of medicine is learned through reflection, attention, awareness and most of all from great role models. Glad you find one and hopefully many more!

Absolutely awesome! I admire this so much. This resident recognized not only the medical problem, but the patient who had the problem and how it affected his life. He also provided support and resources. To me this is medicine at its finest.

--, I was particularly struck by a couple of aspects of this essay. One is that your nephrologist (I hope) was able to combine genuine caring and involvement with his patients with the ability to still fall asleep each night. This exemplifies the balance that a physician role model of mine described as "knowing when to get into the canoe with the patient and knowing when to step out."

The other thing I noticed was your use of the words "passion" and "responsibility" to describe this doctor. These words do not always go together (passionate people are not always responsible people) but when they do, something wonderful occurs. Passion implies a kind of love of what one does; and it can transform the duty of patient care into a privilege. As physicians, you are instructed to be dutiful, and this is an essential quality in medicine. No one tells you to be passionate; but if you can find the passion in what you do, I believe you will be happier and find it is easier to connect and care about your patients, as does the role model you chose.

Dear --, you extracted a lot of valuable lessons from this encounter - eliciting the patient's point of view, knowledge of their situation, and fears, showing them you care about their wellbeing, being a good listener and having the courage to tell the truth are all essential qualities for gaining patients' trust and making them feel you will do everything you can to help them.

I'm glad you saw these lessons so clearly. That tells me you already knew them, and this clinical encounter simply served to reinforce your existing art of doctoring awareness.

--, I always love reading this final essay because I discover colleagues whom I don't know but who inspire and motivate students to be amazing doctors. I do not know Dr. X, but I am so glad she is at our institution.

Your essay does a superb job not only of saying "Dr X is awesome" but analyzing the qualities and skills she brings to each clinical encounter to be such an effective physician. It's also true that neither of the examples you give are especially time-consuming. They are small things (holding a hand, making a statement that is simultaneously honest and supportive) that nevertheless make a huge difference.

Finally, I loved that you said "I will have to develop my own style." Very true. You have been fortunate enough to learn from Dr. X and many others. You will take everything you've learned, filter it through who you are, your own values and convictions, and what emerges will be your best version of yourself as a doctor (and likely as a human being). I am absolutely confident that your patients too will feel seen, heard, valued, and respected.

This encounter was very well-observed, --. It was a simple procedure, yet you learned a lot from it: 1) Be honest with the patient, always, but especially about pain 2) Include the patient in what is to come 3) Count down pain and give the patient a break.

To these excellent ideas, I would add expressing regret while emphasizing the necessity. "I wish there was a way to do this painlessly, but it's important to clean the abscess to avoid further complications." This approach speaks to your point of acknowledging that it is impossible to avoid a certain amount of pain, while letting the patient know that you wish you could spare them.

All of these practices show the alignment of the physician with the patient. They become a team navigating a difficult but necessary procedure, one in which each must do their part for a favorable outcome.

--, it is great you wrote about Dr. X. I'm not sure if you're aware he has background in theater (he acts in local productions), and I think this contributes to his awareness of body language, tone, and other nonverbal behavior.

I'm impressed by your close observation of Dr. X so that you discovered not only that he is an excellent clinician, but how he communicates patient-centeredness and respect to his patients. Body language, careful listening, asking permission are all ways of signaling respect for and interest in the patient.

I also appreciated that you are wrestling with how to translate an internist's style to the ED. It is not that it cannot be done, but you will have to adapt Dr. X's more leisurely pace to the requirements of a busy ED. I'd encourage you to chart your own course, and to remember that while you don't need to look just like Dr. X, you may not need to imitate everything that goes on between physicians and patients in the ED. Find the docs you admire in that setting (they will be there) and they will be your role models. It is by no means impossible to combine compassion and efficiency - in fact, the one often complements the other.

--, Dr. X is a great role model and I'm glad you paid special attention to his interaction. He is very skillful and not getting "hooked" by a patient's emotion, and knowing how to go beneath the surface to get to the real problem.

I also agree with the lesson of not taking things personally. Although I think it is always worthwhile to question yourself (have I done anything that has triggered the patient's anger?; have I acted in a way that is less than kind, empathic, and professional?), if the answer is no, then you can realize that you are not the cause of the patient's anger although it appears to be directed at you. Instead, you are a convenient target for fears and suffering that seem to have no one to hold responsible (God?). Easier to blame the doctor. If you don't react in kind, if you keep calm and attentive, as Dr. X knows how to do, you can often de-escalate the emotional tone, and win the patient's trust.

I especially appreciated your point that, when you do not take the patient's feelings personally, it is easier to avoid being defensive and retaliatory, so that in the end you will be able to provide better care to the patient.

--, thank you for this observant essay. You did a great job of analyzing what diffused this potentially fraught encounter and made it so effective. Simple things like body

language, appropriate physical contact, and taking an extra couple of minutes, as you pointed out so well, can make all the difference. I also am glad the experience caused you to think about how relationship can be longitudinal or cross-sectional, and can be meaningful in both manifestations. Finally, you make an excellent point that the nature of the doctor-patient relationship can look quite different depending on specialty, but it remains the bedrock of all good medicine.

--, I appreciate that you singled out this comment. It is a practice of the mind/heart that many physicians I respect use. Especially when they are feeling detached, remote, uncaring, they simply say to themselves, this patient could be my grandmother; or this patient is someone's grandmother. It is surprising how quickly this simple statement shifts emotions and reestablishes connection.

The self-protective decision to "care less" seems easy, but can have its own negative consequences. As we've discussed many times in class, it's about balance. Too much involvement leads to empathic distress, which results in attention being removed from the patient and turned to soothe the self of the physician. Too little involvement eliminates the rewards of clinical practice and leads to burn-out. Seek the Middle Way!

--, your essay exemplifies why healthcare diversity is such a benefit, both from a moral and a pragmatic perspective. This patient did not receive all the care he should have from the healthcare system; but he did receive all the care and assistance that his surgeon could offer. The surgeon put his patient at the center of the interaction, and in doing so earned his trust. This act both conveys solidarity with the patient and commits the physician to working for his patient, even if that means looking for work-arounds to the system. In this case, by acknowledging and attempting to ameliorate the structural issues that constrained optimal healthcare for this patient, this surgeon clearly aligned himself with the patient, not with the healthcare system. There is nothing more important when facing life and death issues than to feel there is someone fighting on your behalf.

--, thanks for this essay, which shows your sensitivity both to the patients' plight and to Dr. X's emotional skill in interacting with them. As you point out, listening done well and attentively can be truly healing. When people feel understood, they begin to feel less alone. When they feel less alone, they begin to feel hopeful. This hope will help them through what lies ahead. So although listening may seem like "nothing," in some situations it is "everything."

You clearly appreciated Dr. X's ability to focus attentively on her patients with respect and lack of judgment. These are wonderful lessons to internalize and it is apparent you have already done so. Keep listening!

--, this is an excellent reflection. You realize that we have a choice about how we respond to others. If they disappoint or manipulate us, do we take that personally, and punish them in return through our contempt or skepticism? Or do we see their fear, flaws, and vulnerability, and choose a response of compassion and hope? that all human beings, not merely the nice, cooperative ones, deserve respect and care (they may also need boundaries). By acknowledging our shared humanity, by recognizing that we cannot truly know the struggles of another, we can approach even very difficult situations with a low likelihood of a successful outcome with humility and hope.

Thank you for mentioning your breath practice. Breath anchors us to life, and it is an effective and quick reminder to seek calmness, nonjudgmentalness, and discernment. It is amazing how a few deep breaths bring us back to the person we want to be in any given situation.

--, this was an interesting experience because it reminds us that individual doctors can make choices that allow them to practice the kind of patient-centered medicine they want. It involves sacrifice (presumably lower salary), and doctors should not have to consider such options but for those who feel comfortable giving up some financial rewards for delivering high quality patient care, it is a really admirable decision.

I also appreciated your sensitivity to how Dr. X phrased his inquiry about patient questions. You analyzed the effects of the different statements perfectly. One pushes the patient away, while the other invites (almost expects, as you say) an interaction.

--, I'd just like to say what a pleasure it has been to have you in class. The more you spoke out, the more I got to know you; and I developed a great respect for your nuanced, perceptive contributions. Wishing you best of luck in matching in the residency of your choice.

Dear --, your essay is an excellent analysis of why it is almost always better to confront a problem with patient/family than try to avoid. You're right, it SEEMS faster to slink away into another patient's room; but that family member will pursue you to the ends of the earth, with greater and greater intensity, because she perceives she is fighting for her son. Often, you discover when you sit down for an authentic, honest, yet caring conversation, the person's demandingness, anger, start to dissolve and their sorrow and fear start to surface. In that place, it is much easier to focus everything toward making the last phase of the patient's life as comfortable and meaningful as possible.

I especially liked that you recognized just how hard it is to take the non-avoidant approach during residency. Yet simply by recognizing this, you are more likely to remember the benefits of a more direct approach and to make this effort despite limited time and many pressures. To your delight, I predict you will feel better about yourself as a physician and be surprised at how often (not always!) difficulties resolve and everyone is able to get on the same page in this critical moment.

--, I like the way you described surgeon and resident as "toggling" back and forth between highly technical and highly emotional interactions. This is a behavioral skill and, with practice, can be learned or strengthened. I believe it has to do with being fully present in whatever situation you find yourself - performing an intricate surgical procedure or talking with a distraught family.

You are also absolutely right that after you've seen one BBN, you've seen... one. Every patient/family is going to react differently, although you may recognize certain

similar elements in disparate circumstances. This can be disconcerting or intimidating because there is no "formula" for dealing with a family's grief. On the other hand, by paying careful attention to what is happening in the room, you can use your foundational knowledge about loss and grief to build a unique approach tailored to that patient and family.

Your final insight is also excellent. If you take a moment to ask yourself, what will most help this family, often you will find answers emerging. Trust them.

--, thank you for pointing out that we learn as much if not more from bad as from good role models. In this case, you've analyzed the problem well. This physician has a hard job (chronic pain management) and it appears to have overwhelmed him. That is very understandable, and should not be judged. However, it is also not an excuse for treating patients in an unfeeling, demeaning manner. In the doctor-patient encounter, the patient is always the more vulnerable. Although both may be suffering, it is the obligation of the physician to address both the patient's suffering AND his/her own if needed. It is something of a paradox, but by embracing the emotions of the patient (not getting lost in them, but not being afraid of them), one can reclaim the meaning of medicine.

--, you loved your resident's approach; and I loved the way it mattered to you. I also loved that you adopted it yourself, and took the added step of giving patients a heads up of what to expect from the team. Your final observation, that one person wearing the authority of the white coat (most patients don't understand the short/long distinction - to them you are all "doctors") can make a huge difference for the patient is so well-taken. I think too often students (and doctors) rationalize inaction by thinking to themselves, "It will take extra time to do x or y, and it won't make any difference anyway." Wrong. Small gestures of compassion are meaningful and ones that patients long remember.

--, your essay made excellent points about paraphrasing, validating, listening, and attending to nonverbal cues. You are very wise in realizing that not every problem can be solved, at least not initially; and that it matters very much to patients to feel

they are seen and heard; and that they have someone who will help them move forward in the best way possible. This is a critical role not only for a child psychiatrist, but for a pediatrician as well. That you recognize this at this early point in your training augurs well for the way you will support and attend to your patients in the future.

--, I too have learned so much from Dr. X (and I'm not even a doctor). I admire her immensely, particularly because she is able to form such respectful, caring relationships within the ED setting. In fact, she was the doctor who convinced me that continuity care is not necessary for a meaningful relationship to develop.

Your essay succeeds very well not only in admiring Dr. X but in parsing what makes her such an effective and humanistic physician. Everything you highlight, from her interactions with staff to her teaching of residents to her approach with diverse patients, speaks to her constant professionalism, which is grounded in always putting the patient at the center.

I was especially struck by your observation that she does not respond negatively to situations that are inherently challenging, such as the need for an interpreter or a patient who does not buy in to the treatment plan. It is really worth considering how you can prepare for these inevitable scenarios and how you can stay patient, calm, and eager to help. Dr. X's example shows this is not only possible but with practice can become a very positive habit.

--, I was fascinated by the way you showed how the physician's "spiel" in most cases could be adapted to integrate patient questions without throwing the doctor off his stride. I'd say the main potential downside is ignoring questions that don't "fit" into the physician's framework, although in your limited observation this did not appear to happen.

I like the fact you are thinking proactively how to "see" and "hear" patients in a busy ED setting. You are absolutely right that you will not often have the time to "dig deep." And I'd guess that the ED has much greater variety of complaints than a sports medicine clinic, so developing appropriate "spiels" might be more challenging.

Nevertheless, it seems an excellent approach to begin to develop the key points you wish to communicate to every patient you see with a broken bone or who is having a heart attack etc.; and then to listen carefully to patient questions so you can relate them to the essential information you need to convey.

Most importantly, this kind of proactive thinking about both what you need to do as a physician and what your patients need from you will make you a skillful and attentive physician.

--, you learned a lot from this observation about what makes a good family physician and really what makes any physician excel. Seeing the patient as a person, acknowledging limits of one's knowledge, and understanding how the disease affects the patient emotionally and mentally come into play in every clinical interaction. Knowing this, and know the importance of these qualities, will contribute significantly to your ability to practice the art of medicine.

I'm glad you had the opportunity to work with this resident; and I'm glad his behavior has lingered in your memory. I agree completely that "even in the toughest circumstances" - and I might even amend that to say, 'ESPECIALLY in the toughest circumstances," extra effort in the manner you describe makes the patient, who is incredibly sick, suffering, and afraid, reassured and SEEN. This is a doctor who still cares about me, the patient might think. And this comforts them, helps them absorb what the physician is explaining, and allows them to be a participant in the decision-making that may follow.

Hi --, thank you for sharing this encounter. You had a superb role model, who knew exactly the steps to take in a high affect situation to reduce fear and give the patient a feeling that the situation was in control. Everything you mention - language preference, introductions, clarification of patient/family knowledge, attention to social context and medical issues, preservation of some sort of hope - are vital components of a BBN experience that, while difficult, leaves the patient feeling that there is a path forward.

Your comment about the family's influence on the mood of the patient was perceptive. In such a situation, it is important for the physician to pay attention not only to the patient's reaction but to the family's, because the one will feed off the other. Creating a context of calm, even while accepting the distraught emotions of patient/family, conveys the hope that together (as you pointed out Dr. X stressed), patient and doctor can navigate even this most difficult of paths.

Finally, I appreciated that you noticed the "uncomfortable pause" and recognized how much value this can have. When someone asks "any questions?" then rapidly moves on to something else, it feels pro forma and insincere. By contrast, Dr. X's body language suggests he is really interested in and ready to engage with any questions, concerns, thoughts, and feelings that arise.