COMMENTS – AOD ASSIGNMENT #1 2007

--, with the perspective of eight years, this sounds pretty funny (I hope you agree). Your reconsidered dialogue would probably have been preferable – buying a little time, recognizing heat of battle emotions, and taking a little time out. Well, if she was "the one," I hope you were able to patch things up. If not, then I hope you've "moved on." ☺. Best, Dr. Shapiro

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--, isn't it interesting how we sometimes "hang on" to even very "minor" incidents. If we can release them after a bit, then they probably were minor. If we keep thinking about them, they may have more significance. Personally, I am a conflict-avoider. I don't like to confront people because I don't like to stir up conflict. What I have learned is that there are ways to address issues directly but not aggressively (the other person can still come back with hostility, but it is likely to be at least a bit muted). For example, in this case, you might proceed as follows.

--: Excuse me, honored and revered intern. It's come to my attention that you think my cohort and I lack any interest in this surgical rotation and are lower than dust. Could this be the case? (checking out the validity of this third-party communication, which in general should be avoided if possible)
Nasty intern: That barely begins to scratch the surface! (rumor is confirmed)
--: I am truly sad to hear that (expressing regret at intern's bad opinion, whether justified or not). I'm wondering what I might have done to give you this impression and what I can do to correct it (trying to establish your goal).
Nasty intern: When I said hello to you, you just said hello back, and didn't rave about how much you are loving this rotation.
--: Thank you, oh wise intern, for clarifying how this awful misunderstanding arose. In fact, I'm planning on going into surgery, and am fascinated by every piece of scut work I'm asked to perform. I apologize for not expressing my ecstasy earlier. I'm also wondering if you happened to notice the careful history I took of Mr. X; and how I stayed all night at Mrs. Y's bedside after her appendectomy; as well as the way I cleaned up the entire OR, even though this is not technically part of my responsibilities (pointing out competence and behavior beyond the call of duty).
Nasty intern: Hmm. Now that you mention it, I did hear about the OR thing. I guess that shows dedication.
--: Thank you for noticing my humble efforts, marvelous intern. Let's keep communicating about any concerns you have; as well as anything you think I'm doing with a modicum of skill.
Nasty intern: Well… it's a deal. (Hugs and smiles all around).

Thanks for sharing. Best, Dr. Shapiro

Thanks, --, for owning up with such honesty to less-than-perfect behavior. Patients make physicians angry a lot, sometimes with reason and sometimes not. Sometimes all of us are pushed past our limits (because we are exhausted, hungry, or simply have stress overload); and then we often behave in ways we regret afterwards. There is no question that a patient glaring and throwing ice would make me angry too. What I would want to do – and like as not wouldn't do, because I'd react too quickly – is take a breath, and think about her perspective, which might include lack of lucidity, helplessness, fear, and extreme discomfort. Thinking about the patient might soften my anger, and enable me to reach down deep inside myself and find a little kindness and reassurance. Also, as you point out, remembering that the patient's reaction likely has very little to do with me, and a lot more to do with her suffering might make me a little more compassionate. But the reality is that all of us (except maybe the Dalai Lama) are flawed human beings. When we do something we regret, all we can do is reflect on it – without beating ourselves up – learn what we can, forgive ourselves, and get ready for the next encounter. Best, Dr. Shapiro

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Haha, --, that is a really interesting anecdote. I admire your thoroughness. And I really admire your confessing your "failure" to the fellow. Luckily, your skills are intact and you did learn something new. The only thing I wonder about is whether you said anything to the patient during those 7 minutes which I'm sure were excruciating for you, but perhaps distressing for the patient as well. On the other hand, maybe he was laughing up his sleeve (haha, this poor slob doesn't realize I have Takayasu's and it will be a cold day in hell before he gets a blood pressure!). In any event, I appreciate your honesty and humility – there is always more to learn. Best, Dr. Shapiro

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--, I'm glad we got to discuss this incident in class, because it sounds distressing on many levels: the resident ignored you, the attending attacked and humiliated you; and meanwhile the poor patient was kind of left dangling. Even worse, it was not an isolated incident – you were subjected to abuse during the entire sub-I. I feel badly that you had to endure this experience. As we explored, it is so hard as the lowest person on the totem-pole (except the screaming patient) to confront people who have more power over you. Regrettably, both the resident and attending physician, the people you rely on as your role-models, behaved unprofessionally. Equally regrettably, there was nothing for you to learn in the way the situation was handled, except to get out of the clutches of these individuals as quickly as possible! The only lesson for you to take away is the importance of taking responsibility for your mistakes, even when you have the power to avoid doing so. Never humiliate your subordinates and learners, although you can teach them. Always admit your mistakes in judgment, even when someone less senior was right, and you were wrong. I am truly sorry you went through this. This is definitely NOT how medical education should be. Best, Dr. Shapiro

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--, the dialogue you observed would be funny if it weren't so sad (and potentially dangerous to the patient's well-being). Especially troubling is the misrepresentation the fellow made to the attending. To be honest, I see this more often than I'd like while observing resident-patient encounters. What actually happens in the exam room versus how the resident presents the interview to the attending is sometimes night and day. I agree with you completely about 20-20 hindsight. The danger is that, after uncomfortable situations have occurred and a little tiny part of our brain is hinting we could have done better, most of us have a tendency to scurry away from them as quickly as we can and bury them as deeply as possible. Unfortunately, this we don't learn anything, and so are likely to keep repeating the same mistakes. I also agree that it is beyond hard to take the initiative as the bottom of the totem pole; and I would NEVER say, "Oh --, you should have done this or that." Only the individual involved in the situation knowing all the pros and cons can make that determination. But by considering other options, we expand the range of possibilities for ourselves; and therefore can feel more comfortable with the choices we make. I really like the idea of approaching the fellow and offering to translate. This shows empathy for the fellow's plight – perhaps with her limited Spanish, the only choice she felt she had was to "fake" knowledge of the patient. Btw, this is obviously an egregious choice morally; and someone needs to confront it – not necessarily the medical student; but the first step in bringing it to light is not to attack, but to help. It is very sad that the medical education system is so punitive that the fellow is caught in such a double bind; rather than assisted in problem-solving a more humane and patient-centered approach to her Spanish-speaking patients. Thanks for sharing this dilemma. Regrettably, I suspect it will not be the last time you observe something of a similar nature. Perhaps next time, you will have more power. Remember to use it! – but wisely and compassionately. Best, Dr. Shapiro

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--, this is a great example, because it describes an experience so many students have been through. It shows how "oppressed" we can become by people who have "power over" us. It also shows how, by giving into feelings of helplessness, we can then expend even more energy by having to vent and thrash ourselves when we can finally identify a "safe" person. I can relate, because I have gone through exactly the same process many times myself. I like your ideas for "replaying" this situation, although of course much easier to say than to do. Part of becoming a physician is owning your adulthood, even in situations that may belittle and infantilize you. When you are treated like a child (and occasionally an abused child), it is easy to act like one. It is hard, but not impossible, to make the choice to reclaim your own voice. Finally, I absolutely agree that "happy," well-adjusted physicians make for happy, well-adjusted patients. You cannot take care of others until you have learned to take care of yourself. Maybe trite, but certainly true. Best, Dr. Shapiro

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--, what a terribly unprofessional and nasty way for this resident to behave. I think you are wise to realize that you might handle this situation differently as a fourth year than as a third year. Last year you made a choice to not confront the resident out of concern for your grade; and you ended up honoring. Since you were the one absorbing the abuse (and not a patient, for example), this seems like a very reasonable choice. And, in fact, by mentioning this incident to the clerkship director, you did call the resident to account in a way. Now, with more knowledge and less to lose, you might take a more confrontive stance. As we discussed in class, it depends what your goals are. Your goal might be to protect your grade. Or it might be to humiliate the resident (for example, by public demonstrating her error) as she humiliated you (a very natural response by the way). Your goal might be to get her punished (by reporting her to the clerkship director). Your goal might even be to help her become a less punitive teacher (if you thought there was a way to actually talk with her). Or your goal might be to let the encounter go as the ravings of an unpleasant, vicious person. When you take responsibility for what you want, then you can pursue it wholeheartedly. By reflecting on what you *really* want, you are usually able to eliminate some of our more automatic, reflexive responses ("I'd like to slug that witch") and figure out more worthwhile goals. Thanks for sharing. Dr. Shapiro

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--, this was a very interesting situation you presented, and I'm glad we got to discuss it in class. Basically, the nurse's behavior that you describe is not only unprofessional, but borders on the pathological, and certainly scary. Yet much as you might want to simply avoid such people, that is not always possible. Sometimes they are your patients, sometimes your colleagues, and once in awhile, your boss. In dealing with very angry, out-of-control individuals, there are some helpful guidelines to follow: 1) Get them to sit down if possible (people tend to be more aggressive standing than sitting) 2) Allow them to vent for a little while, rather than interrupting 3) Don't defend yourself right away, it won't help 4) Paraphrase their perceptions – this is not the same as agreeing, but allows the person to feel heard 5) Apologize, not necessarily for anything you've done, but for the fact that your actions have upset them 6) Make a specific request ("Let's try to work this out") 7) Set limits if necessary ("I'd really like to work out this misunderstanding, but we can't continue to talk unless you stop calling me names") 8) Extend the system ("Let's bring in a third person"). This was really a tough one. Thanks for bringing it to our attention. Best, Dr. Shapiro

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--, I was really impressed by your creative problem-solving in class on Tuesday. You have excellent communication and psychosocial skills.

I really liked the way you expanded the assignment to consider how "personal" physician failures are often influenced/produced by systemic failures. Absolutely! Many of us are still guilty of too often thinking of medicine as a dyadic relationship between two individuals; whereas in fact, that dyadic relationship is always operating within a larger societal context. You are absolutely right that the solution to such patient failures should not fall solely on the shoulders of individual physicians; and that the hands of even dedicated doctors are tied by systemic constraints.

Your essay, while disillusioned, is also extremely well-written. I was moved by the phrase "I am simply like the wind…"; and by your caustic observation, "She works the same hours as a doctor." It is also insightful. Your ideas regarding management (boundaries, limits, contracts, appropriate pain management) are exactly right in terms of taking back some control of this patient. Plus a lot of patience and compassion. Yet to do so the physician needs a comprehensive health care system to support his or her efforts. And of course you are also exactly right that this is the job of the pcp, not the medical student. I think all anyone can do (medical student, physician, human being) in an unfair, unjust, broken system, is ask themselves what can I do (imperfect as it is)? Then do it, and ask forgiveness and forgive oneself for not being able to do more. Thank you for once again demonstrating your outside-the-box thinking. Best, Dr. Shapiro

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--, thank you for reflecting on this distressing, horrifying (at least to a non-physician) case. One of the truths of medicine is that, unlike many premeds anticipate, it is full of uncertainties and ambiguities. I imagine you are correct in saying it is impossible to know with certainty whether the condition of the small bowel was due to the tears; and it is impossible to know whether the heart attack was attributable to the (iatrogenic) complications during surgery. Nevertheless, it is obviously indisputable that the surgeon behaved in a dangerously hasty and careless manner, as witnessed by repeatedly making the same mistake. It is doubly troubling to think that the surgeon may have thought he could be careless because this uninsured patient "didn't matter" and would not cause trouble. So many wrongs!

I certainly agree that the third year medical student should not bear the brunt of responsibility in this situation, and I hope the resident addressed the surgeon's behavior in some fashion. I think the plan you propose makes a lot of sense. Confronting the surgeon would, in my opinion, be useless. On the other hand, talking with the resident (with the goal of encouraging him/her not to sweep this under the rug); and approaching the chair of the department might (as you say) lead to intervention. We are always weighing the potential personal cost of making waves against protecting the welfare of vulnerable, defenseless patients who often do not have an effective voice in the healthcare system. In this case, I'd say this surgeon needs feedback. Maybe he was

having a bad day, who knows? But to me, it's crossing a line when personal stress, bias, etc. translates into dangerous patient care.

I'm very troubled by this incident, but I really appreciate your sharing it. Best, Dr. Shapiro

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What a painful incident, --. You bumped against a very prevalent mentality in NICU, PICU environments which is both a blessing and a curse (read neonatal intensivist John Lantos for a thoughtful contrary opinion). Pediatricians are very reluctant to let go of their little charges – and up to a point with good reason. Most of us feel a despair to see the end of a life that has barely begun; and kids can be remarkably resilient, and sometimes far surpass their medical prognoses. Yet as Lantos suggests, this extreme unwillingness to consider "palliative care" (I'm not even sure I've heard this exact term used in NICU/PICU settings) can do a terrible injustice to both tiny patient and family. We now know that suffering in infants is real (you are probably way too young to realize that doctors used to assert infants "did not feel pain"). So this is a crucial debate that needs to occur openly. Yet many pediatricians are reluctant to have it.

I am very sorry that your desire to pursue this conversation resulted in punishment by the attending, both at the time and in your evaluation. Of course, what you observed was an example of unreflective transference, where the attending's personal family situation colored her response to her patients (and her medical students!). Unfortunately, there is no way to set such life experiences "aside." I'm sure if you queried this attending, she would say she is completely objective and her sibling is irrelevant in the way she practices medicine. Personally, I believe a better (in the sense of more effective in seeing the whole picture) approach is to pay attention to our emotions, attitudes, and beliefs. An attending who thoughtfully considered how her personal circumstances affected her viewpoint could turn this aspect of her life into a compassionate and insightful resource.

Thanks -- for sharing such a difficult moment. And by the way, I'm really glad you spoke up. It was the right thing to do. I'm only sorry it met with such a punitive reaction. Like the resident, the best doctors need to be prepared to "shift the ground" of their discourse. Sadly, too few are. Dr. Shapiro

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Hi --, I'm glad you were able to make it to class to share your experience. I really wanted to talk about this incident, because it spoke so poignantly to the consequences of making mistakes (often so costly in medicine, yet still unavoidable); and the natural (but even more morally wrong) tendency to cover up our mistakes, refuse to take responsibility for them, and glide over them in a way that implies they never happened. Such reactions leave the one wronged (in this case, this poor young woman) feeling isolated, unheard, and abandoned. Thoughtless (and cruel) mistake compounded by tragedy!

As we discussed, there are several lessons to be learned here. One, as you point out, is to try to take the time to be prepared for each patient. Sounds like a no-brainer, right? But in

the press of residency (and beyond) and high patient volume, no one is always as prepared as s/he should be. So mistakes will happen. I think the second lesson is even harder – to admit wrong-doing. Here the attending might rationalize – oh well, no big deal. I didn't cut off the wrong leg or anything. But in fact it is obvious from the patient's retort that she was deeply wounded (in fact, the remark likely created pain; but also accessed a larger suffering over the loss of her uterus and her childbearing capacity that still needed to be attended to). The third lesson is that most of us have an ancillary tendency to "cover-up" for those who have power over us; or whom we identify with (our colleagues, peers, team), as the resident did. Again, in an ideal educational system, we could address such issues with the goal not of blaming but of learning.

Thanks so much for bringing all of this to our attention. Best, Dr. Shapiro P.S. Hmm, could any of these lessons have implications for our political leaders?

Great reflection, --. You really got a lot out of what must have been an uncomfortable and scary experience. You showed a great deal of insight: namely, that a lot of the problem (on both sides) was based on faulty assumptions which, if clarified, could have caused everyone to "work together," instead of going off in different directions. Everyone was "just doing their job" but no one was really aware of what the "job" of the other was. The result was inadvertently putting the medical student in some jeopardy.

I also admired your awareness that opening the door was a "passive-aggressive" act; and that direct communication at that point might have recruited the security guard to your side (literally!). When we become lost in our own perspective, we tend to simply continue to act on it (I need this door open for my safety!) rather than considering other strategies. I also was quite impressed with your awareness of countertransference issues. This is so true. Once again, the key is awareness. Once you become conscious of fear, you can assess, is it justified? (in this case, yes!); is it negatively affecting my interaction with the patient? (in this case, no – in fact, your demeanor obviously enabled the patient to open up and disclose sensitive information to you). Without awareness, your fear/negative judgment etc. may adversely affect your treatment of the patient.

This paper showed nuanced thinking and impressive self-awareness. Dr. Shapiro

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--, the behavior of this resident as you describe it is not only unprofessional, it rises to the level of unacceptable practice; and she did need to be called to account. You use strong language toward yourself in retrospect: "ashamed." It is very hard for third years to step forward in such a direct manner. Speaking with the course director was an appropriate alternative; hopefully this individual took action. Setting limits on and naming unprofessional behavior are powerful (and moral) responses. We don't always take them, nor can we. But they are always important to consider. I think what is best in what you describe is that a) you did not rationalize this resident's behavior, but recognized it for what it was b) in one short year, you have grown personally in confidence and courage so

that you now know how to address similar situations. You should forgive yourself for your silence last year; and be proud of your growth. Best, Dr. Shapiro